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: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/24/2022 5:25 pm

PART I - COST REPORT STATUS

Provider use only
1. [X] Electronically prepared cost report — Date: 5/24/2022 Time: 5:25 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 RIVERVIEW HOSPITAL (15-0059) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	544,311	-133,918	0	-16,854	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	46,772	-45		-54,726	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	591,083	-133,963	0	-71,580	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: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2022 5:25 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 395 WESTFIELD ROAD	PO Box:			1.00
2.00	City: NOBLESVILLE	State: IN	Zip Code: 46060-	County: HAMILTON	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	RIVERVIEW HOSPITAL	150059	26900	1	07/07/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	RIVERVIEW HOSPITAL REHAB	15T059	26900	5	01/01/1994	N	P	O	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)	01/01/2021	12/31/2021	20.00
21.00	Type of Control (see instructions)	9		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2022 5:25 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	387	1,127	0	0	2,209	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.	13	143	0	0	219		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	Y	Y	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	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: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 5:25 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.	Y	Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 5:25 pm

		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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 5:25 pm

		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

		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

		V	XIX	
		1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	838,003	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 5:25 pm

		1.00	2.00	
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		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		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: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/24/2022 5:25 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.	Y	A	07/30/2020	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/15/2022	Y	03/15/2022	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/24/2022 5:25 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?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/24/2022 5:25 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.	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: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2022 5:25 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	104	37,960	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)		104	37,960	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	15	5,475	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		119	43,435	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	24	8,760		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		143				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: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I Date/Time Prepared: 5/24/2022 5:25 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)	3,853	375	13,024			1.00
2.00	HMO and other (see instructions)	3,905	3,224				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	888	362				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)	3,853	375	13,024			7.00
8.00	INTENSIVE CARE UNIT	961	0	4,199			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		0	1,512			13.00
14.00	Total (see instructions)	4,814	375	18,735	0.00	988.34	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	2,277	13	4,301	0.00	18.79	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			167			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	1,007.13	27.00
28.00	Observation Bed Days		0	2,697			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	124	259			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: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I Date/Time Prepared: 5/24/2022 5:25 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,014	64	4,429	1.00
2.00	HMO and other (see instructions)			705	638		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				33		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,014	64	4,429	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	198	2	372	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part II Date/Time Prepared: 5/24/2022 5:25 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	91,856,500	113,670	91,970,170	2,094,834.45	43.90	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		27,254,850	411,228	27,666,078	480,067.15	57.63	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,866,311	0	1,866,311	24,835.00	75.15	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		494,312	0	494,312	3,093.00	159.82	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		12,797,338	0	12,797,338			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		4,492,333	0	4,492,333			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part II Date/Time Prepared: 5/24/2022 5:25 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	642,312	0	642,312	17,961.25	35.76	26.00
27.00	Administrative & General	5.00	9,288,756	-224,231	9,064,525	264,914.50	34.22	27.00
28.00	Administrative & General under contract (see inst.)		240,373	0	240,373	570.80	421.12	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,327,716	0	2,327,716	71,395.50	32.60	30.00
31.00	Laundry & Linen Service	8.00	74,226	0	74,226	4,353.00	17.05	31.00
32.00	Housekeeping	9.00	1,071,687	0	1,071,687	49,806.75	21.52	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,298,666	-940,111	358,555	16,847.42	21.28	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	792,376	792,376	37,231.43	21.28	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	703,058	0	703,058	16,103.25	43.66	38.00
39.00	Central Services and Supply	14.00	715,680	0	715,680	26,994.50	26.51	39.00
40.00	Pharmacy	15.00	2,600,303	-263,493	2,336,810	59,045.00	39.58	40.00
41.00	Medical Records & Medical Records Library	16.00	798,359	0	798,359	26,611.50	30.00	41.00
42.00	Social Service	17.00	697,256	0	697,256	18,477.75	37.73	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part III Date/Time Prepared: 5/24/2022 5:25 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		92,096,873	113,670	92,210,543	2,095,405.25	44.01	1.00
2.00	Excluded area salaries (see instructions)		27,254,850	411,228	27,666,078	480,067.15	57.63	2.00
3.00	Subtotal salaries (line 1 minus line 2)		64,842,023	-297,558	64,544,465	1,615,338.10	39.96	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,360,623	0	2,360,623	27,928.00	84.53	4.00
5.00	Subtotal wage-related costs (see inst.)		12,797,338	0	12,797,338	0.00	19.83	5.00
6.00	Total (sum of lines 3 thru 5)		79,999,984	-297,558	79,702,426	1,643,266.10	48.50	6.00
7.00	Total overhead cost (see instructions)		20,458,392	-635,459	19,822,933	610,312.65	32.48	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part IV Date/Time Prepared: 5/24/2022 5:25 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,051,457	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	9,066,844	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	220,398	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	37,369	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	261,719	14.00
15.00	'Workers' Compensation Insurance	240,555	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	6,309,901	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	75,288	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	26,140	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	17,289,671	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part V | Date/Time Prepared: 5/24/2022 5:25 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,866,311	17,289,671	1.00
2.00	Hospital	1,866,311	17,289,671	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/24/2022 5:25 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.277128	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,831,105	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	56,946,568	6.00
7.00	Medicaid cost (line 1 times line 6)	15,781,488	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	11,950,383	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	11,950,383	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	8,906,140	511,410	9,417,550	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,468,141	511,410	2,979,551	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,468,141	511,410	2,979,551	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	13,619,952	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	45,321	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	69,724	27.01
28.00	Non-Medicare bad debt expense (see instructions)	13,550,228	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	3,779,551	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	6,759,102	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	18,709,485	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/24/2022 5:25 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		20,307,539	20,307,539	-381,448	19,926,091	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	642,312	7,518,044	8,160,356	718,940	8,879,296	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,288,756	30,701,868	39,990,624	381,448	40,372,072	5.00
7.00	00700	OPERATION OF PLANT	2,327,716	6,499,238	8,826,954	0	8,826,954	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	74,226	1,703,637	1,777,863	0	1,777,863	8.00
9.00	00900	HOUSEKEEPING	1,071,687	972,062	2,043,749	0	2,043,749	9.00
10.00	01000	DIETARY	1,298,666	1,919,273	3,217,939	-2,335,139	882,800	10.00
11.00	01100	CAFETERIA	0	0	0	1,963,413	1,963,413	11.00
13.00	01300	NURSING ADMINISTRATION	703,058	98,132	801,190	0	801,190	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	715,680	965,670	1,681,350	7,467,701	9,149,051	14.00
15.00	01500	PHARMACY	2,600,303	18,276,230	20,876,533	-276,859	20,599,674	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	798,359	546,336	1,344,695	0	1,344,695	16.00
17.00	01700	SOCIAL SERVICE	697,256	143,404	840,660	0	840,660	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	266,402	266,402	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,110,616	1,830,658	11,941,274	-488,408	11,452,866	30.00
31.00	03100	INTENSIVE CARE UNIT	3,536,181	837,374	4,373,555	-345,099	4,028,456	31.00
41.00	04100	SUBPROVIDER - IRF	1,550,026	1,048,790	2,598,816	-88,788	2,510,028	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,085,657	8,936,467	13,022,124	-3,776,466	9,245,658	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,075,588	704,146	2,779,734	-4,330	2,775,404	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	506,441	596,386	1,102,827	-2,197	1,100,630	55.00
57.00	05700	CT SCAN	362,125	176,806	538,931	-95,777	443,154	57.00
57.01	03630	ULTRA SOUND	412,391	39,776	452,167	-3,267	448,900	57.01
58.00	05800	MRI	317,641	91,970	409,611	-5,958	403,653	58.00
59.00	05900	CARDIAC CATHETERIZATION	873,436	1,810,711	2,684,147	-956,699	1,727,448	59.00
60.00	06000	LABORATORY	3,271,149	6,258,158	9,529,307	-2,586	9,526,721	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	639,279	639,279	0	639,279	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,767,743	522,227	2,289,970	-121,877	2,168,093	65.00
66.00	06600	PHYSICAL THERAPY	5,128,917	1,575,780	6,704,697	-7,236	6,697,461	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	592,340	183,915	776,255	-70	776,185	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,292,762	11,292,762	0	11,292,762	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	393,780	393,780	-2,506	391,274	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	835,217	593,427	1,428,644	-122,252	1,306,392	76.01
76.02	03070	WOMEN'S CENTER	453,963	159,856	613,819	-80,683	533,136	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	342,674	176,636	519,310	-31,089	488,221	90.00
90.01	09001	OUTPATIENT	676,899	825,684	1,502,583	-251,515	1,251,068	90.01
90.02	09002	NEUROPSYCHOLOGY	311,763	113,843	425,606	-40	425,566	90.02
91.00	09100	EMERGENCY	8,722,890	26,140,938	34,863,828	-1,120,253	33,743,575	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	52,557	37,791	90,348	0	90,348	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,204,233	154,638,593	220,842,826	297,362	221,140,188	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	83,838	121,896	205,734	0	205,734	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,358,727	9,590,782	29,949,509	-658,479	29,291,030	192.00
192.01	19201	FOUNDATION	206,030	14,617	220,647	0	220,647	192.01
192.02	19202	CLINICS	966,750	207,272	1,174,022	-1,116	1,172,906	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	-224	-224	0	-224	192.03
192.04	19207	WESTFIELD SCHOOLS	1,176,014	160,938	1,336,952	-799	1,336,153	192.04
192.05	19203	PRACTICE MANAGEMENT	377,399	546,988	924,387	0	924,387	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	41,601	41,601	0	41,601	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	143,326	143,326	0	143,326	192.08
192.09	19209	BEHAVIOR CARE	408,146	164,338	572,484	-1	572,483	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	139	253	392	0	392	193.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/24/2022 5:25 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	
193.02	19302	UNIVERSITY HS ATHLETICS	60,475	5,377	65,852	0	65,852	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	541,135	90,753	631,888	0	631,888	193.03
193.04	19304	OB/GYN SPEC GATHERS	132,315	23,333	155,648	0	155,648	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	565,328	115,586	680,914	0	680,914	193.05
193.06	19306	OUTPATIENT PHARMACY	534,485	3,682,189	4,216,674	0	4,216,674	193.06
194.00	07950	WORKMED	241,486	253,262	494,748	-3,037	491,711	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	366,070	366,070	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	91,856,500	169,800,880	261,657,380	0	261,657,380	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/24/2022 5:25 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	-21,162	19,904,929		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-52,763	8,826,533		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-15,356,550	25,015,522		5.00
7.00	00700	OPERATION OF PLANT	-8,400	8,818,554		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,777,863		8.00
9.00	00900	HOUSEKEEPING	0	2,043,749		9.00
10.00	01000	DIETARY	0	882,800		10.00
11.00	01100	CAFETERIA	-725,585	1,237,828		11.00
13.00	01300	NURSING ADMINISTRATION	-5,816	795,374		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,149,051		14.00
15.00	01500	PHARMACY	-5,449,029	15,150,645		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,722	1,342,973		16.00
17.00	01700	SOCIAL SERVICE	0	840,660		17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	266,402		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	11,452,866		30.00
31.00	03100	INTENSIVE CARE UNIT	-216	4,028,240		31.00
41.00	04100	SUBPROVIDER - IRF	0	2,510,028		41.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,207,534	7,038,124		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,609	2,771,795		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,100,630		55.00
57.00	05700	CT SCAN	-2,891	440,263		57.00
57.01	03630	ULTRA SOUND	-632	448,268		57.01
58.00	05800	MRI	0	403,653		58.00
59.00	05900	CARDIAC CATHETERIZATION	-735,000	992,448		59.00
60.00	06000	LABORATORY	-181,393	9,345,328		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	639,279		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	2,168,093		65.00
66.00	06600	PHYSICAL THERAPY	-81,894	6,615,567		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	-95,769	680,416		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,292,762		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	391,274		74.00
76.00	03020	OTHER ANCILLARY	0	0		76.00
76.01	03140	CARDIAC REHAB	-583	1,305,809		76.01
76.02	03070	WOMEN'S CENTER	-540	532,596		76.02
76.03	03330	ENDOSCOPY	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	488,221		90.00
90.01	09001	OUTPATIENT	-5,450	1,245,618		90.01
90.02	09002	NEUROPSYCHOLOGY	0	425,566		90.02
91.00	09100	EMERGENCY	-13,223,408	20,520,167		91.00
91.01	09101	SHORT STAY	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-1,750	88,598		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-38,161,696	182,978,492		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	205,734		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	29,291,030		192.00
192.01	19201	FOUNDATION	0	220,647		192.01
192.02	19202	CLINICS	0	1,172,906		192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	-224		192.03
192.04	19207	WESTFIELD SCHOOLS	0	1,336,153		192.04
192.05	19203	PRACTICE MANAGEMENT	0	924,387		192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	41,601		192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0		192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	143,326		192.08
192.09	19209	BEHAVIOR CARE	0	572,483		192.09
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	392		193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	65,852		193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	631,888		193.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
193.04	19304	OB/GYN SPEC GATHERS	0	155,648	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	680,914	193.05
193.06	19306	OUTPATIENT PHARMACY	0	4,216,674	193.06
194.00	07950	WORKMED	0	491,711	194.00
194.01	07951	MEALS ON WHEELS	0	366,070	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-38,161,696	223,495,684	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	792,376	1,171,037	1.00
	TOTALS		792,376	1,171,037	
	B - MEALS ON WHEELS RECLASS				
1.00	MEALS ON WHEELS	194.01	147,735	218,335	1.00
	TOTALS		147,735	218,335	
	C - INSURANCE RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	381,448	1.00
	TOTALS		0	381,448	
	D - MEDICAL SUPPLY RECLASS				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,467,701	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
	TOTALS		0	7,467,701	
	E - RSMA RECLASS				
1.00	OPERATING ROOM	50.00	337,901		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		6,921	2.00
	TOTALS		337,901	6,921	
	F - PARAMED ED RECLASS				
1.00	PARAMED ED PRGM PHARMACY	23.00	263,493	2,909	1.00
	TOTALS		263,493	2,909	
	G - COMMUNITY RELATIONS RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	224,231	1.00
	TOTALS		0	224,231	
	H - ALLOCATED BENEFITS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	712,019	1.00
	TOTALS		0	712,019	
500.00	Grand Total: Increases		1,541,505	10,184,601	500.00

RECLASSIFICATIONS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/24/2022 5:25 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	792,376	1,171,037	0		1.00
	TOTALS		792,376	1,171,037			
	B - MEALS ON WHEELS RECLASS						
1.00	DIETARY	10.00	147,735	218,335	0		1.00
	TOTALS		147,735	218,335			
	C - INSURANCE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	381,448	12		1.00
	TOTALS		0	381,448			
	D - MEDICAL SUPPLY RECLASS						
1.00	DIETARY	10.00		5,656	0		1.00
2.00	PHARMACY	15.00		10,457	0		2.00
3.00	ADULTS & PEDIATRICS	30.00		488,408	0		3.00
4.00	INTENSIVE CARE UNIT	31.00		345,099	0		4.00
5.00	SUBPROVIDER - IRF	41.00		88,788	0		5.00
6.00	OPERATING ROOM	50.00		3,769,545	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00		4,330	0		7.00
8.00	RADIOLOGY-THERAPEUTIC	55.00		2,197	0		8.00
9.00	CT SCAN	57.00		95,777	0		9.00
10.00	ULTRA SOUND	57.01		3,267	0		10.00
11.00	MRI	58.00		5,958	0		11.00
12.00	CARDIAC CATHETERIZATION	59.00		956,699	0		12.00
13.00	LABORATORY	60.00		2,586	0		13.00
14.00	RESPIRATORY THERAPY	65.00		121,877	0		14.00
15.00	PHYSICAL THERAPY	66.00		7,236	0		15.00
16.00	ELECTROCARDIOLOGY	69.00		70	0		16.00
17.00	RENAL DIALYSIS	74.00		2,506	0		17.00
18.00	CARDIAC REHAB	76.01		122,252	0		18.00
19.00	WOMEN'S CENTER	76.02		80,683	0		19.00
20.00	CLINIC	90.00		31,089	0		20.00
21.00	OUTPATIENT	90.01		251,515	0		21.00
22.00	NEUROPSYCHOLOGY	90.02		40	0		22.00
23.00	EMERGENCY	91.00		408,234	0		23.00
24.00	PHYSICIANS' PRIVATE OFFICES	192.00		658,479	0		24.00
25.00	CLINICS	192.02		1,116	0		25.00
26.00	WESTFIELD SCHOOLS	192.04		799	0		26.00
27.00	BEHAVIOR CARE	192.09		1	0		27.00
28.00	WORKMED	194.00		3,037	0		28.00
	TOTALS		0	7,467,701			
	E - RSMA RECLASS						
1.00	OPERATING ROOM	50.00	0	344,822	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	344,822			
	F - PARAMED ED RECLASS						
1.00	PHARMACY	15.00	263,493	2,909	0		1.00
	TOTALS		263,493	2,909			
	G - COMMUNITY RELATIONS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	224,231	0	0		1.00
	TOTALS		224,231	0			
	H - ALLOCATED BENEFITS RECLASS						
1.00	EMERGENCY	91.00	0	712,019	0		1.00
	TOTALS		0	712,019			
500.00	Grand Total: Decreases		1,427,835	10,298,271			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I Date/Time Prepared: 5/24/2022 5:25 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	15,961,384	89,030	0	89,030	0	1.00
2.00	Land Improvements	3,160,234	70,856	0	70,856	0	2.00
3.00	Buildings and Fixtures	165,529,203	644,100	0	644,100	0	3.00
4.00	Building Improvements	1,399,855	0	0	0	0	4.00
5.00	Fixed Equipment	51,814,379	0	0	0	1,513,898	5.00
6.00	Movable Equipment	117,243,801	4,811,441	0	4,811,441	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	355,108,856	5,615,427	0	5,615,427	1,513,898	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	355,108,856	5,615,427	0	5,615,427	1,513,898	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	16,050,414	0	1.00
2.00	Land Improvements	3,231,090	0	2.00
3.00	Buildings and Fixtures	166,173,303	0	3.00
4.00	Building Improvements	1,399,855	0	4.00
5.00	Fixed Equipment	50,300,481	0	5.00
6.00	Movable Equipment	122,055,242	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	359,210,385	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	359,210,385	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II | Date/Time Prepared: 5/24/2022 5:25 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	20,307,539	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	20,307,539	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	20,307,539	1.00
3.00	Total (sum of lines 1-2)	0	20,307,539	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III Date/Time Prepared: 5/24/2022 5:25 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	359,210,385	0	359,210,385	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	359,210,385	0	359,210,385	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	20,307,539	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	20,307,539	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-21,162	-381,448	0	0	19,904,929	1.00
3.00	Total (sum of lines 1-2)	-21,162	-381,448	0	0	19,904,929	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/24/2022 5:25 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	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-20,031,154			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	281,651			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-424,000	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
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	HAF EXPENSE	A	-9,077,065	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/24/2022 5:25 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	
33.01	ADMINISTRATION RECRUITMENT/SPECIAL E	A	-11,478	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER REV MEDICAL REPORT	B	-1,722	MEDICAL RECORDS & LIBRARY	16.00	0	33.02
33.03	OTHER REVENUES ->PURCHASE DISCOUNTS	B	-42,680	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	RADIOLOGY- OTHER REVENUE-CDS FOR LEG	B	-2,957	RADIOLOGY-DIAGNOSTIC	54.00	0	33.04
33.05	AMBULANCE OTHER REVENUE	B	-1,750	AMBULANCE SERVICES	95.00	0	33.05
33.06	LABORATORY -> OTHER REVENUE	B	-181,393	LABORATORY	60.00	0	33.06
33.07	MATERNITY CENER OTHER REVNEU	B	-8,400	OPERATION OF PLANT	7.00	0	33.07
33.08	INFORMATION SYSTEMS OTHER REV	B	-540	WOMEN'S CENTER	76.02	0	33.08
33.09	ADMINISTRATION LEAN TEAM	B	-429	EMERGENCY	91.00	0	33.09
33.10	EDUCATION -> OTHER REVENUE	B	-14,872	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OP PHARMACY REVENUE	A	-5,449,029	PHARMACY	15.00	0	33.11
33.12	DIETARY SALES PR DEDUCT	B	-209,027	CAFETERIA	11.00	0	33.12
33.13	WELLNESS SERVICES - EXTERNAL->-OTHER	B	-14,909	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	OTHER REV PREMIER PROGRAM	B	0	CENTRAL SERVICES & SUPPLY	14.00	0	33.14
33.15	WESTFIELD BISTRO-OTHER REVENUE	B	-92,558	CAFETERIA	11.00	0	33.15
33.16	NON-OP REV -> MISCELLANEOUS INTEREST	B	-21,162	CAP REL COSTS-BLDG & FIXT	1.00	11	33.16
33.17	COMMUNITY RELATIONS	A	-2,114,993	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	COMMUNITY RELATIONS BENEFITS	A	-26,396	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19	CRNA	A	-725,250	OPERATING ROOM	50.00	0	33.19
33.20	IHA LOBBYING EXPENSE	A	-5,836	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	CV SERVICES-OTHER REVENUE	B	-120	ELECTROCARDIOLOGY	69.00	0	33.21
33.22	CT SCAN-OTHER REVENUE	B	-2,891	CT SCAN	57.00	0	33.22
33.23	FISCAL SERVICES COMMERCE BANK REBATE	B	-91,897	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	ULTRASOUND - OTHER REVENUE	B	-632	ULTRA SOUND	57.01	0	33.24
33.25	WOUND CARE-OTHER REVENUE	B	-5,450	OUTPATIENT	90.01	0	33.25
33.26	NON-OP EXPENSE INVESTMENT FEES	A	118,699	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	OTHER MISC REVENUE	B	1,196	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	RVH MEDICATION MGMT CLINIC	B	0	LABORATORY	60.00	0	33.28
33.29	OTHER REV RADIOLOGY FILM	B	-652	RADIOLOGY-DIAGNOSTIC	54.00	0	33.29
33.30	ADMIN DONATIONS	B	-4,000	ADMINISTRATIVE & GENERAL	5.00	0	33.30
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-38,161,696				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: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet A-8-1 Date/Time Prepared: 5/24/2022 5:25 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	50.00	OPERATING ROOM	OPERATING ROOM	648,548	366,897	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	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			648,548	366,897	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	RSMA	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2022 5:25 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	281,651	0	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	281,651		5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2022 5:25 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	11,458	11,458	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	4,113,624	4,113,624	0	0	0	2.00
3.00	13.00	NURSING ADMINISTRATION	5,816	5,816	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	216	216	0	0	0	4.00
5.00	50.00	OPERATING ROOM	1,763,935	1,763,935	0	0	0	5.00
6.00	59.00	CARDIAC CATHETERIZATION	735,000	735,000	0	0	0	6.00
7.00	66.00	PHYSICAL THERAPY	81,894	81,894	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	95,649	95,649	0	0	0	8.00
9.00	76.01	CARDIAC REHAB	583	583	0	0	0	9.00
10.00	90.02	NEUROPSYCHOLOGY	235,361	0	235,361	211,500	2,518	10.00
11.00	91.00	EMERGENCY	13,222,979	13,222,979	0	0	0	11.00
200.00			20,266,515	20,031,154	235,361		2,518	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	6.00
7.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	76.01	CARDIAC REHAB	0	0	0	0	0	9.00
10.00	90.02	NEUROPSYCHOLOGY	256,037	12,802	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
200.00			256,037	12,802	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	11,458	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	4,113,624	2.00
3.00	13.00	NURSING ADMINISTRATION	0	0	0	5,816	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	216	4.00
5.00	50.00	OPERATING ROOM	0	0	0	1,763,935	5.00
6.00	59.00	CARDIAC CATHETERIZATION	0	0	0	735,000	6.00
7.00	66.00	PHYSICAL THERAPY	0	0	0	81,894	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	95,649	8.00
9.00	76.01	CARDIAC REHAB	0	0	0	583	9.00
10.00	90.02	NEUROPSYCHOLOGY	0	256,037	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	13,222,979	11.00
200.00			0	256,037	0	20,031,154	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	19,904,929	19,904,929				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,826,533	83,737	8,910,270			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,015,522	1,531,217	884,371	27,431,110	27,431,110	5.00
7.00	00700	OPERATION OF PLANT	8,818,554	6,782,925	227,101	15,828,580	2,214,545	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,777,863	46,168	7,242	1,831,273	256,210	8.00
9.00	00900	HOUSEKEEPING	2,043,749	37,347	104,558	2,185,654	305,790	9.00
10.00	01000	DIETARY	882,800	403,643	34,982	1,321,425	184,878	10.00
11.00	01100	CAFETERIA	1,237,828	0	77,307	1,315,135	183,998	11.00
13.00	01300	NURSING ADMINISTRATION	795,374	0	68,593	863,967	120,876	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,149,051	221,003	69,825	9,439,879	1,320,715	14.00
15.00	01500	PHARMACY	15,150,645	275,611	227,989	15,654,245	2,190,154	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,342,973	73,329	77,891	1,494,193	209,050	16.00
17.00	01700	SOCIAL SERVICE	840,660	52,133	68,027	960,820	134,426	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	266,402	4,918	25,707	297,027	41,556	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,452,866	2,973,842	986,432	15,413,140	2,156,422	30.00
31.00	03100	INTENSIVE CARE UNIT	4,028,240	443,433	345,004	4,816,677	673,892	31.00
41.00	04100	SUBPROVIDER - IRF	2,510,028	474,085	151,227	3,135,340	438,659	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,038,124	1,606,481	431,580	9,076,185	1,269,831	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,771,795	421,634	202,503	3,395,932	475,118	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,100,630	227,698	49,410	1,377,738	192,757	55.00
57.00	05700	CT SCAN	440,263	0	35,330	475,593	66,539	57.00
57.01	03630	ULTRA SOUND	448,268	0	40,235	488,503	68,345	57.01
58.00	05800	MRI	403,653	0	30,990	434,643	60,810	58.00
59.00	05900	CARDIAC CATHETERIZATION	992,448	74,884	85,216	1,152,548	161,251	59.00
60.00	06000	LABORATORY	9,345,328	461,710	319,146	10,126,184	1,416,734	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	639,279	78,374	0	717,653	100,405	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,168,093	46,707	172,468	2,387,268	333,998	65.00
66.00	06600	PHYSICAL THERAPY	6,615,567	149,070	500,398	7,265,035	1,016,437	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	680,416	210,563	57,791	948,770	132,741	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,292,762	0	0	11,292,762	1,579,948	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	391,274	29,478	0	420,752	58,867	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	1,305,809	349,003	81,487	1,736,299	242,922	76.01
76.02	03070	WOMEN'S CENTER	532,596	292,460	44,290	869,346	121,628	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	488,221	76,502	33,433	598,156	83,687	90.00
90.01	09001	OUTPATIENT	1,245,618	111,406	66,041	1,423,065	199,098	90.01
90.02	09002	NEUROPSYCHOLOGY	425,566	53,878	30,417	509,861	71,334	90.02
91.00	09100	EMERGENCY	20,520,167	672,749	851,040	22,043,956	3,084,126	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	88,598	8,662	5,128	102,388	14,325	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	182,978,492	18,274,650	6,393,159	178,831,102	21,182,072	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	205,734	191,017	8,180	404,931	56,653	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29,291,030	1,439,262	1,986,238	32,716,530	4,577,378	192.00
192.01	19201	FOUNDATION	220,647	0	20,101	240,748	33,683	192.01
192.02	19202	CLINICS	1,172,906	0	94,320	1,267,226	177,295	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	-224	0	0	-224	0	192.03
192.04	19207	WESTFIELD SCHOOLS	1,336,153	0	114,737	1,450,890	202,991	192.04
192.05	19203	PRACTICE MANAGEMENT	924,387	0	36,821	961,208	134,481	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	41,601	0	0	41,601	5,820	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	143,326	0	0	143,326	20,052	192.08

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
192.09	19209	BEHAVIOR CARE	572,483	0	39,820	612,303	85,666	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	392	0	14	406	57	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	65,852	0	5,900	71,752	10,039	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	631,888	0	52,795	684,683	95,793	193.03
193.04	19304	OB/GYN SPEC GATHERS	155,648	0	12,909	168,557	23,582	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	680,914	0	55,156	736,070	102,982	193.05
193.06	19306	OUTPATIENT PHARMACY	4,216,674	0	52,146	4,268,820	597,242	193.06
194.00	07950	WORKMED	491,711	0	23,560	515,271	72,091	194.00
194.01	07951	MEALS ON WHEELS	366,070	0	14,414	380,484	53,233	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	223,495,684	19,904,929	8,910,270	223,495,684	27,431,110	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	18,043,125					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	72,391	2,159,874				8.00
9.00	00900	HOUSEKEEPING	58,560	0	2,550,004			9.00
10.00	01000	DIETARY	632,915	0	5,000	2,144,218		10.00
11.00	01100	CAFETERIA	0	0	70,000	0	1,569,133	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	20,448	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	346,533	17,504	2,500	0	34,278	14.00
15.00	01500	PHARMACY	432,159	0	62,500	0	72,150	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	114,980	0	12,500	0	36,616	16.00
17.00	01700	SOCIAL SERVICE	81,745	0	0	0	23,463	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	7,712	0	0	0	2,825	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,663,005	729,940	857,503	1,453,372	288,209	30.00
31.00	03100	INTENSIVE CARE UNIT	695,306	170,169	122,500	197,427	68,705	31.00
41.00	04100	SUBPROVIDER - IRF	743,368	181,944	157,500	493,419	49,633	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,518,972	226,022	420,001	0	148,876	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	661,125	136,371	40,000	0	70,901	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	357,031	18,840	25,000	0	11,869	55.00
57.00	05700	CT SCAN	0	0	0	0	12,075	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	10,859	57.01
58.00	05800	MRI	0	0	2,500	0	9,418	58.00
59.00	05900	CARDIAC CATHETERIZATION	117,418	60,086	0	0	21,532	59.00
60.00	06000	LABORATORY	723,964	0	157,500	0	123,741	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	122,891	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	73,237	0	7,500	0	47,078	65.00
66.00	06600	PHYSICAL THERAPY	233,742	19,636	12,500	0	179,931	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	330,165	19,986	100,000	0	19,894	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	46,221	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	547,239	1,719	67,500	0	25,206	76.01
76.02	03070	WOMEN'S CENTER	458,578	11,616	62,500	0	18,787	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	119,956	3,151	0	0	13,749	90.00
90.01	09001	OUTPATIENT	174,685	63,268	17,500	0	20,312	90.01
90.02	09002	NEUROPSYCHOLOGY	84,482	0	0	0	6,647	90.02
91.00	09100	EMERGENCY	1,054,875	314,337	212,500	0	184,180	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	13,583	0	0	0	2,179	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,486,838	1,974,589	2,415,004	2,144,218	1,523,561	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	299,516	0	2,500	0	4,594	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,256,771	183,694	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	6,098	192.01
192.02	19202	CLINICS	0	827	132,500	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	764	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
192.09	19209	BEHAVIOR CARE	0	0	0	0	0	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	203	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	0	0	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	0	2,641	193.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	0	5,214	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193.05
193.06	19306	OUTPATIENT PHARMACY	0	0	0	0	18,007	193.06
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	8,815	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,043,125	2,159,874	2,550,004	2,144,218	1,569,133	202.00

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,005,291					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,161,409				14.00
15.00	01500	PHARMACY	0	0	18,411,208			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,867,339		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	1,200,454	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	490,468	0	0	528,899	1,034,176	30.00
31.00	03100	INTENSIVE CARE UNIT	116,922	0	0	264,450	73,262	31.00
41.00	04100	SUBPROVIDER - IRF	84,465	0	0	0	93,016	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	291,434	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	21,588	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	16,191	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	340,007	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	26,985	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,161,409	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	18,411,208	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	286,037	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	313,436	0	0	70,160	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,005,291	11,161,409	18,411,208	1,845,751	1,200,454	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
192.02	19202	CLINICS	0	0	0	21,588	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
192.09	19209	BEHAVIOR CARE	0	0	0	0	0	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	0	0	193.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	0	0	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	0	0	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193.05
193.06	19306	OUTPATIENT PHARMACY	0	0	0	0	0	193.06
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,005,291	11,161,409	18,411,208	1,867,339	1,200,454	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
23.00	02300	PARAMED ED PRGM PHARMACY	349,120					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	27,615,134	0	27,615,134		30.00
31.00	03100	INTENSIVE CARE UNIT	0	7,199,310	0	7,199,310		31.00
41.00	04100	SUBPROVIDER - IRF	0	5,377,344	0	5,377,344		41.00
43.00	04300	NURSERY	0	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	13,951,321	0	13,951,321		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,779,447	0	4,779,447		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,004,823	0	2,004,823		55.00
57.00	05700	CT SCAN	0	554,207	0	554,207		57.00
57.01	03630	ULTRA SOUND	0	567,707	0	567,707		57.01
58.00	05800	MRI	0	507,371	0	507,371		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,512,835	0	1,512,835		59.00
60.00	06000	LABORATORY	0	12,564,314	0	12,564,314		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	940,949	0	940,949		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	2,849,081	0	2,849,081		65.00
66.00	06600	PHYSICAL THERAPY	0	9,067,288	0	9,067,288		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,578,541	0	1,578,541		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,161,409	0	11,161,409		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,872,710	0	12,872,710		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	349,120	18,760,328	0	18,760,328		73.00
74.00	07400	RENAL DIALYSIS	0	525,840	0	525,840		74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0		76.00
76.01	03140	CARDIAC REHAB	0	2,906,922	0	2,906,922		76.01
76.02	03070	WOMEN'S CENTER	0	1,542,455	0	1,542,455		76.02
76.03	03330	ENDOSCOPY	0	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	818,699	0	818,699		90.00
90.01	09001	OUTPATIENT	0	1,897,928	0	1,897,928		90.01
90.02	09002	NEUROPSYCHOLOGY	0	672,324	0	672,324		90.02
91.00	09100	EMERGENCY	0	27,277,570	0	27,277,570		91.00
91.01	09101	SHORT STAY	0	0	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	132,475	0	132,475		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	349,120	169,638,332	0	169,638,332		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	768,194	0	768,194		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	39,734,373	0	39,734,373		192.00
192.01	19201	FOUNDATION	0	280,529	0	280,529		192.01
192.02	19202	CLINICS	0	1,599,436	0	1,599,436		192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	-224	0	-224		192.03
192.04	19207	WESTFIELD SCHOOLS	0	1,653,881	0	1,653,881		192.04
192.05	19203	PRACTICE MANAGEMENT	0	1,096,453	0	1,096,453		192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	47,421	0	47,421		192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	163,378	0	163,378		192.08
192.09	19209	BEHAVIOR CARE	0	697,969	0	697,969		192.09
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
193.01	19301	PHYSICIAN SERVICES-LYONS	0	666	0	666		193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	81,791	0	81,791		193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	783,117	0	783,117		193.03
193.04	19304	OB/GYN SPEC GATHERS	0	197,353	0	197,353		193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	839,052	0	839,052		193.05
193.06	19306	OUTPATIENT PHARMACY	0	4,884,069	0	4,884,069		193.06
194.00	07950	WORKMED	0	587,362	0	587,362		194.00
194.01	07951	MEALS ON WHEELS	0	442,532	0	442,532		194.01
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	349,120	223,495,684	0	223,495,684		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	83,737	83,737	83,737		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,531,217	1,531,217	8,312	1,539,529	5.00
7.00	00700	OPERATION OF PLANT	0	6,782,925	6,782,925	2,135	124,286	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	46,168	46,168	68	14,379	8.00
9.00	00900	HOUSEKEEPING	0	37,347	37,347	983	17,162	9.00
10.00	01000	DIETARY	0	403,643	403,643	329	10,376	10.00
11.00	01100	CAFETERIA	0	0	0	727	10,326	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	645	6,784	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	221,003	221,003	656	74,122	14.00
15.00	01500	PHARMACY	0	275,611	275,611	2,143	122,917	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	73,329	73,329	732	11,732	16.00
17.00	01700	SOCIAL SERVICE	0	52,133	52,133	639	7,544	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	4,918	4,918	242	2,332	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,973,842	2,973,842	9,271	121,024	30.00
31.00	03100	INTENSIVE CARE UNIT	0	443,433	443,433	3,243	37,821	31.00
41.00	04100	SUBPROVIDER - IRF	0	474,085	474,085	1,421	24,619	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,606,481	1,606,481	4,056	71,266	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	421,634	421,634	1,903	26,665	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	227,698	227,698	464	10,818	55.00
57.00	05700	CT SCAN	0	0	0	332	3,734	57.00
57.01	03630	ULTRA SOUND	0	0	0	378	3,836	57.01
58.00	05800	MRI	0	0	0	291	3,413	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	74,884	74,884	801	9,050	59.00
60.00	06000	LABORATORY	0	461,710	461,710	3,000	79,511	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	78,374	78,374	0	5,635	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	46,707	46,707	1,621	18,745	65.00
66.00	06600	PHYSICAL THERAPY	0	149,070	149,070	4,703	57,045	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	210,563	210,563	543	7,450	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	88,671	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	29,478	29,478	0	3,304	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	349,003	349,003	766	13,633	76.01
76.02	03070	WOMEN'S CENTER	0	292,460	292,460	416	6,826	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	76,502	76,502	314	4,697	90.00
90.01	09001	OUTPATIENT	0	111,406	111,406	621	11,174	90.01
90.02	09002	NEUROPSYCHOLOGY	0	53,878	53,878	286	4,003	90.02
91.00	09100	EMERGENCY	0	672,749	672,749	7,999	173,089	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	8,662	8,662	48	804	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	18,274,650	18,274,650	60,088	1,188,793	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	191,017	191,017	77	3,180	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,439,262	1,439,262	18,662	256,918	192.00
192.01	19201	FOUNDATION	0	0	0	189	1,890	192.01
192.02	19202	CLINICS	0	0	0	887	9,950	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	1,078	11,392	192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	346	7,547	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	327	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	1,125	192.08
192.09	19209	BEHAVIOR CARE	0	0	0	374	4,808	192.09

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	3	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	55	563	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	496	5,376	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	121	1,324	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	518	5,780	193.05
193.06	19306	OUTPATIENT PHARMACY	0	0	0	490	33,519	193.06
194.00	07950	WORKMED	0	0	0	221	4,046	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	135	2,988	194.01
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	19,904,929	19,904,929	83,737	1,539,529	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	6,909,346					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,721	88,336				8.00
9.00	00900	HOUSEKEEPING	22,425	0	77,917			9.00
10.00	01000	DIETARY	242,365	0	153	656,866		10.00
11.00	01100	CAFETERIA	0	0	2,139	0	13,192	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	172	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	132,700	716	76	0	288	14.00
15.00	01500	PHARMACY	165,489	0	1,910	0	607	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,030	0	382	0	308	16.00
17.00	01700	SOCIAL SERVICE	31,303	0	0	0	197	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	2,953	0	0	0	24	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,785,627	29,854	26,200	445,230	2,422	30.00
31.00	03100	INTENSIVE CARE UNIT	266,257	6,960	3,743	60,480	578	31.00
41.00	04100	SUBPROVIDER - IRF	284,662	7,441	4,813	151,156	417	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	964,603	9,244	12,833	0	1,252	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	253,168	5,577	1,222	0	596	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	136,720	771	764	0	100	55.00
57.00	05700	CT SCAN	0	0	0	0	102	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	91	57.01
58.00	05800	MRI	0	0	76	0	79	58.00
59.00	05900	CARDIAC CATHETERIZATION	44,964	2,457	0	0	181	59.00
60.00	06000	LABORATORY	277,231	0	4,813	0	1,040	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	47,059	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	28,045	0	229	0	396	65.00
66.00	06600	PHYSICAL THERAPY	89,508	803	382	0	1,513	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	126,432	817	3,056	0	167	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	17,700	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	209,557	70	2,063	0	212	76.01
76.02	03070	WOMEN'S CENTER	175,606	475	1,910	0	158	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	45,935	129	0	0	116	90.00
90.01	09001	OUTPATIENT	66,893	2,588	535	0	171	90.01
90.02	09002	NEUROPSYCHOLOGY	32,351	0	0	0	56	90.02
91.00	09100	EMERGENCY	403,949	12,856	6,493	0	1,548	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,201	0	0	0	18	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,930,454	80,758	73,792	656,866	12,809	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	114,695	0	76	0	39	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	864,197	7,513	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	51	192.01
192.02	19202	CLINICS	0	34	4,049	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	31	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
192.09	19209	BEHAVIOR CARE	0	0	0	0	0	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	2	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	0	0	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	0	22	193.03

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	0	44	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193.05
193.06	19306	OUTPATIENT PHARMACY	0	0	0	0	151	193.06
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	74	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,909,346	88,336	77,917	656,866	13,192	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	7,601					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	429,561				14.00
15.00	01500	PHARMACY	0	0	568,677			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	130,513		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	91,816	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,708	0	0	36,965	79,099	30.00
31.00	03100	INTENSIVE CARE UNIT	884	0	0	18,483	5,603	31.00
41.00	04100	SUBPROVIDER - IRF	639	0	0	0	7,114	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	20,369	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	1,509	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	1,132	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	23,764	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	1,886	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	429,561	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	568,677	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	19,992	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	2,370	0	0	4,904	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,601	429,561	568,677	129,004	91,816	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
192.02	19202	CLINICS	0	0	0	1,509	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
192.09	19209	BEHAVIOR CARE	0	0	0	0	0	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	0	0	193.02

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	0	0	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	0	0	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193.05
193.06	19306	OUTPATIENT PHARMACY	0	0	0	0	0	193.06
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,601	429,561	568,677	130,513	91,816	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
23.00	02300	PARAMED ED PRGM PHARMACY	10,469					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		5,513,242	0	5,513,242		30.00
31.00	03100	INTENSIVE CARE UNIT		847,485	0	847,485		31.00
41.00	04100	SUBPROVIDER - IRF		956,367	0	956,367		41.00
43.00	04300	NURSERY		0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		2,690,104	0	2,690,104		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		710,765	0	710,765		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		378,844	0	378,844		55.00
57.00	05700	CT SCAN		4,168	0	4,168		57.00
57.01	03630	ULTRA SOUND		4,305	0	4,305		57.01
58.00	05800	MRI		3,859	0	3,859		58.00
59.00	05900	CARDIAC CATHETERIZATION		132,337	0	132,337		59.00
60.00	06000	LABORATORY		828,437	0	828,437		60.00
60.01	06001	BLOOD LABORATORY		0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		131,068	0	131,068		63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY		95,743	0	95,743		65.00
66.00	06600	PHYSICAL THERAPY		326,788	0	326,788		66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY		350,914	0	350,914		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		429,561	0	429,561		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		88,671	0	88,671		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		568,677	0	568,677		73.00
74.00	07400	RENAL DIALYSIS		50,482	0	50,482		74.00
76.00	03020	OTHER ANCILLARY		0	0	0		76.00
76.01	03140	CARDIAC REHAB		595,296	0	595,296		76.01
76.02	03070	WOMEN'S CENTER		477,851	0	477,851		76.02
76.03	03330	ENDOSCOPY		0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC		127,693	0	127,693		90.00
90.01	09001	OUTPATIENT		193,388	0	193,388		90.01
90.02	09002	NEUROPSYCHOLOGY		90,574	0	90,574		90.02
91.00	09100	EMERGENCY		1,285,957	0	1,285,957		91.00
91.01	09101	SHORT STAY		0	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		14,733	0	14,733		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	16,897,309	0	16,897,309		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		309,084	0	309,084		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		2,586,552	0	2,586,552		192.00
192.01	19201	FOUNDATION		2,130	0	2,130		192.01
192.02	19202	CLINICS		16,429	0	16,429		192.02
192.03	19206	HOME HEALTH PARTNERSHIP		0	0	0		192.03
192.04	19207	WESTFIELD SCHOOLS		12,470	0	12,470		192.04
192.05	19203	PRACTICE MANAGEMENT		7,924	0	7,924		192.05
192.06	19204	MOB - NOBLESVILLE SQUARE		327	0	327		192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES		0	0	0		192.07
192.08	19205	RIVERVIEW MEDICAL ARTS		1,125	0	1,125		192.08
192.09	19209	BEHAVIOR CARE		5,182	0	5,182		192.09
193.00	19300	NONPAID WORKERS		0	0	0		193.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
193.01	19301	PHYSICIAN SERVICES-LYONS		5	0	5		193.01
193.02	19302	UNIVERSITY HS ATHLETICS		618	0	618		193.02
193.03	19303	OB/GYN SPEC NEMUNAITI		5,894	0	5,894		193.03
193.04	19304	OB/GYN SPEC GATHERS		1,489	0	1,489		193.04
193.05	19305	OB SPECIALISTS DAVENPORT		6,298	0	6,298		193.05
193.06	19306	OUTPATIENT PHARMACY		34,160	0	34,160		193.06
194.00	07950	WORKMED		4,267	0	4,267		194.00
194.01	07951	MEALS ON WHEELS		3,197	0	3,197		194.01
200.00		Cross Foot Adjustments	10,469	10,469	0	10,469		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	10,469	19,904,929	0	19,904,929		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	627,313					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,639	91,327,858				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	48,257	9,064,525	-27,431,110	196,064,798		5.00
7.00	00700	OPERATION OF PLANT	213,767	2,327,716	0	15,828,580	362,650	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,455	74,226	0	1,831,273	1,455	8.00
9.00	00900	HOUSEKEEPING	1,177	1,071,687	0	2,185,654	1,177	9.00
10.00	01000	DIETARY	12,721	358,555	0	1,321,425	12,721	10.00
11.00	01100	CAFETERIA	0	792,376	0	1,315,135	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	703,058	0	863,967	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,965	715,680	0	9,439,879	6,965	14.00
15.00	01500	PHARMACY	8,686	2,336,810	0	15,654,245	8,686	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,311	798,359	0	1,494,193	2,311	16.00
17.00	01700	SOCIAL SERVICE	1,643	697,256	0	960,820	1,643	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	155	263,493	0	297,027	155	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	93,722	10,110,616	0	15,413,140	93,722	30.00
31.00	03100	INTENSIVE CARE UNIT	13,975	3,536,181	0	4,816,677	13,975	31.00
41.00	04100	SUBPROVIDER - IRF	14,941	1,550,026	0	3,135,340	14,941	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,629	4,423,558	0	9,076,185	50,629	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,288	2,075,588	0	3,395,932	13,288	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,176	506,441	0	1,377,738	7,176	55.00
57.00	05700	CT SCAN	0	362,125	0	475,593	0	57.00
57.01	03630	ULTRA SOUND	0	412,391	0	488,503	0	57.01
58.00	05800	MRI	0	317,641	0	434,643	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,360	873,436	0	1,152,548	2,360	59.00
60.00	06000	LABORATORY	14,551	3,271,149	0	10,126,184	14,551	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,470	0	0	717,653	2,470	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,472	1,767,743	0	2,387,268	1,472	65.00
66.00	06600	PHYSICAL THERAPY	4,698	5,128,917	0	7,265,035	4,698	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	6,636	592,340	0	948,770	6,636	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,292,762	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	929	0	0	420,752	929	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	10,999	835,217	0	1,736,299	10,999	76.01
76.02	03070	WOMEN'S CENTER	9,217	453,963	0	869,346	9,217	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,411	342,674	0	598,156	2,411	90.00
90.01	09001	OUTPATIENT	3,511	676,899	0	1,423,065	3,511	90.01
90.02	09002	NEUROPSYCHOLOGY	1,698	311,763	0	509,861	1,698	90.02
91.00	09100	EMERGENCY	21,202	8,722,890	0	22,043,956	21,202	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	273	52,557	0	102,388	273	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	575,934	65,527,856	-27,431,110	151,399,992	311,271	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,020	83,838	0	404,931	6,020	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	45,359	20,358,727	0	32,716,530	45,359	192.00
192.01	19201	FOUNDATION	0	206,030	0	240,748	0	192.01
192.02	19202	CLINICS	0	966,750	0	1,267,226	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	224	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	1,176,014	0	1,450,890	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	377,399	0	961,208	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	41,601	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	143,326	0	192.08

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
192.09	19209	BEHAVIOR CARE	0	408,146	0	612,303	0	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	139	0	406	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	60,475	0	71,752	0	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	541,135	0	684,683	0	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	132,315	0	168,557	0	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	565,328	0	736,070	0	193.05
193.06	19306	OUTPATIENT PHARMACY	0	534,485	0	4,268,820	0	193.06
194.00	07950	WORKMED	0	241,486	0	515,271	0	194.00
194.01	07951	MEALS ON WHEELS	0	147,735	0	380,484	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	19,904,929	8,910,270		27,431,110	18,043,125	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.730458	0.097564		0.139908	49.753550	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		83,737		1,539,529	6,909,346	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000917		0.007852	19.052381	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: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HR)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	67,867					8.00
9.00	00900	HOUSEKEEPING	0	1,020				9.00
10.00	01000	DIETARY	0	2	71,855			10.00
11.00	01100	CAFETERIA	0	28	0	1,235,728		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	16,103	465,210	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	550	1	0	26,995	0	14.00
15.00	01500	PHARMACY	0	25	0	56,820	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5	0	28,836	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	18,478	0	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	2,225	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,936	343	48,704	226,970	226,970	30.00
31.00	03100	INTENSIVE CARE UNIT	5,347	49	6,616	54,107	54,107	31.00
41.00	04100	SUBPROVIDER - IRF	5,717	63	16,535	39,087	39,087	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,102	168	0	117,243	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,285	16	0	55,836	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	592	10	0	9,347	0	55.00
57.00	05700	CT SCAN	0	0	0	9,509	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	8,552	0	57.01
58.00	05800	MRI	0	1	0	7,417	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,888	0	0	16,957	0	59.00
60.00	06000	LABORATORY	0	63	0	97,449	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3	0	37,075	0	65.00
66.00	06600	PHYSICAL THERAPY	617	5	0	141,700	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	628	40	0	15,667	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	54	27	0	19,850	0	76.01
76.02	03070	WOMEN'S CENTER	365	25	0	14,795	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	99	0	0	10,828	0	90.00
90.01	09001	OUTPATIENT	1,988	7	0	15,996	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	5,235	0	90.02
91.00	09100	EMERGENCY	9,877	85	0	145,046	145,046	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	1,716	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,045	966	71,855	1,199,839	465,210	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1	0	3,618	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,772	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	4,802	0	192.01
192.02	19202	CLINICS	26	53	0	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	24	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
192.09	19209	BEHAVIOR CARE	0	0	0	0	0	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HR)	
			8.00	9.00	10.00	11.00	13.00	
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	160	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	0	0	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	2,080	0	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	4,106	0	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193.05
193.06	19306	OUTPATIENT PHARMACY	0	0	0	14,181	0	193.06
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	6,942	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,159,874	2,550,004	2,144,218	1,569,133	1,005,291	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.825099	2,500.003922	29.840902	1.269805	2.160940	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	88,336	77,917	656,866	13,192	7,601	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.301605	76.389216	9.141549	0.010675	0.016339	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: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	PARAMED ED PRGM PHARMACY (ASSIGNED TIME)	
			14.00	15.00	16.00	17.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100					14.00
15.00	01500	PHARMACY	0	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	346			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	4,801		17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	0	100	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	98	4,136	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	49	293	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	372	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	54	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	4	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	3	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	63	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	5	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	100	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	53	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	13	0	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	342	4,801	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
192.02	19202	CLINICS	0	0	4	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
192.09	19209	BEHAVIOR CARE	0	0	0	0	0	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/24/2022 5:25 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	PARAMED ED PRGM PHARMACY (ASSIGNED TIME)	
			14.00	15.00	16.00	17.00	23.00	
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	0	0	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	0	0	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	0	0	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193.05
193.06	19306	OUTPATIENT PHARMACY	0	0	0	0	0	193.06
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	11,161,409	18,411,208	1,867,339	1,200,454	349,120	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	111,614.090000	184,112.080000	5,396.933526	250.042491	3,491.200000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	429,561	568,677	130,513	91,816	10,469	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4,295.610000	5,686.770000	377.205202	19.124349	104.690000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/24/2022 5:25 pm

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		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	27,615,134		27,615,134	0	27,615,134	30.00
31.00	03100	INTENSIVE CARE UNIT	7,199,310		7,199,310	0	7,199,310	31.00
41.00	04100	SUBPROVIDER - IRF	5,377,344		5,377,344	0	5,377,344	41.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,951,321		13,951,321	0	13,951,321	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,779,447		4,779,447	0	4,779,447	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,004,823		2,004,823	0	2,004,823	55.00
57.00	05700	CT SCAN	554,207		554,207	0	554,207	57.00
57.01	03630	ULTRA SOUND	567,707		567,707	0	567,707	57.01
58.00	05800	MRI	507,371		507,371	0	507,371	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,512,835		1,512,835	0	1,512,835	59.00
60.00	06000	LABORATORY	12,564,314		12,564,314	0	12,564,314	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	940,949		940,949	0	940,949	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,849,081	0	2,849,081	0	2,849,081	65.00
66.00	06600	PHYSICAL THERAPY	9,067,288	0	9,067,288	0	9,067,288	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	1,578,541		1,578,541	0	1,578,541	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,161,409		11,161,409	0	11,161,409	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,872,710		12,872,710	0	12,872,710	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,760,328		18,760,328	0	18,760,328	73.00
74.00	07400	RENAL DIALYSIS	525,840		525,840	0	525,840	74.00
76.00	03020	OTHER ANCILLARY	0		0	0	0	76.00
76.01	03140	CARDIAC REHAB	2,906,922		2,906,922	0	2,906,922	76.01
76.02	03070	WOMEN'S CENTER	1,542,455		1,542,455	0	1,542,455	76.02
76.03	03330	ENDOSCOPY	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	818,699		818,699	0	818,699	90.00
90.01	09001	OUTPATIENT	1,897,928		1,897,928	0	1,897,928	90.01
90.02	09002	NEUROPSYCHOLOGY	672,324		672,324	0	672,324	90.02
91.00	09100	EMERGENCY	27,277,570		27,277,570	0	27,277,570	91.00
91.01	09101	SHORT STAY	0		0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,737,496		4,737,496		4,737,496	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	132,475		132,475	0	132,475	95.00
200.00		Subtotal (see instructions)	174,375,828	0	174,375,828	0	174,375,828	200.00
201.00		Less Observation Beds	4,737,496		4,737,496		4,737,496	201.00
202.00		Total (see instructions)	169,638,332	0	169,638,332	0	169,638,332	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/24/2022 5:25 pm

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		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	40,685,928		40,685,928			30.00
31.00	03100	INTENSIVE CARE UNIT	14,315,544		14,315,544			31.00
41.00	04100	SUBPROVIDER - IRF	6,620,772		6,620,772			41.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,788,344	82,568,404	99,356,748	0.140416	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,057,180	12,362,919	14,420,099	0.331443	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	123,459	9,797,425	9,920,884	0.202081	0.000000	55.00
57.00	05700	CT SCAN	4,552,542	18,736,469	23,289,011	0.023797	0.000000	57.00
57.01	03630	ULTRA SOUND	1,229,163	8,146,989	9,376,152	0.060548	0.000000	57.01
58.00	05800	MRI	695,065	6,447,646	7,142,711	0.071033	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,198,976	17,015,118	27,214,094	0.055590	0.000000	59.00
60.00	06000	LABORATORY	18,594,663	50,503,702	69,098,365	0.181832	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,242,612	546,277	1,788,889	0.525996	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	7,704,992	2,148,118	9,853,110	0.289156	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,833,651	23,450,272	31,283,923	0.289839	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,559,343	8,593,775	11,153,118	0.141534	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,134,512	28,749,474	46,883,986	0.238064	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,919,176	16,438,780	22,357,956	0.575755	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,024,653	45,377,274	63,401,927	0.295895	0.000000	73.00
74.00	07400	RENAL DIALYSIS	696,544	10,116	706,660	0.744120	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03140	CARDIAC REHAB	747,576	15,495,537	16,243,113	0.178963	0.000000	76.01
76.02	03070	WOMEN'S CENTER	13,836	7,757,630	7,771,466	0.198477	0.000000	76.02
76.03	03330	ENDOSCOPY	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	48,945	5,397,966	5,446,911	0.150305	0.000000	90.00
90.01	09001	OUTPATIENT	225,347	8,018,568	8,243,915	0.230222	0.000000	90.01
90.02	09002	NEUROPSYCHOLOGY	0	1,812,692	1,812,692	0.370898	0.000000	90.02
91.00	09100	EMERGENCY	4,853,922	52,000,991	56,854,913	0.479775	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0.000000	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,306,231	5,580,084	6,886,315	0.687958	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	185,172,976	426,956,226	612,129,202			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	185,172,976	426,956,226	612,129,202			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.140416	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.331443	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.202081	55.00
57.00	05700	CT SCAN	0.023797	57.00
57.01	03630	ULTRA SOUND	0.060548	57.01
58.00	05800	MRI	0.071033	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.055590	59.00
60.00	06000	LABORATORY	0.181832	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.525996	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.289156	65.00
66.00	06600	PHYSICAL THERAPY	0.289839	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.141534	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.238064	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.575755	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.295895	73.00
74.00	07400	RENAL DIALYSIS	0.744120	74.00
76.00	03020	OTHER ANCILLARY	0.000000	76.00
76.01	03140	CARDIAC REHAB	0.178963	76.01
76.02	03070	WOMEN'S CENTER	0.198477	76.02
76.03	03330	ENDOSCOPY	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.150305	90.00
90.01	09001	OUTPATIENT	0.230222	90.01
90.02	09002	NEUROPSYCHOLOGY	0.370898	90.02
91.00	09100	EMERGENCY	0.479775	91.00
91.01	09101	SHORT STAY	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.687958	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/24/2022 5:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	27,615,134		27,615,134	0	27,615,134	30.00
31.00	03100	INTENSIVE CARE UNIT	7,199,310		7,199,310	0	7,199,310	31.00
41.00	04100	SUBPROVIDER - IRF	5,377,344		5,377,344	0	5,377,344	41.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,951,321		13,951,321	0	13,951,321	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,779,447		4,779,447	0	4,779,447	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,004,823		2,004,823	0	2,004,823	55.00
57.00	05700	CT SCAN	554,207		554,207	0	554,207	57.00
57.01	03630	ULTRA SOUND	567,707		567,707	0	567,707	57.01
58.00	05800	MRI	507,371		507,371	0	507,371	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,512,835		1,512,835	0	1,512,835	59.00
60.00	06000	LABORATORY	12,564,314		12,564,314	0	12,564,314	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	940,949		940,949	0	940,949	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,849,081	0	2,849,081	0	2,849,081	65.00
66.00	06600	PHYSICAL THERAPY	9,067,288	0	9,067,288	0	9,067,288	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	1,578,541		1,578,541	0	1,578,541	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,161,409		11,161,409	0	11,161,409	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,872,710		12,872,710	0	12,872,710	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,760,328		18,760,328	0	18,760,328	73.00
74.00	07400	RENAL DIALYSIS	525,840		525,840	0	525,840	74.00
76.00	03020	OTHER ANCILLARY	0		0	0	0	76.00
76.01	03140	CARDIAC REHAB	2,906,922		2,906,922	0	2,906,922	76.01
76.02	03070	WOMEN'S CENTER	1,542,455		1,542,455	0	1,542,455	76.02
76.03	03330	ENDOSCOPY	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	818,699		818,699	0	818,699	90.00
90.01	09001	OUTPATIENT	1,897,928		1,897,928	0	1,897,928	90.01
90.02	09002	NEUROPSYCHOLOGY	672,324		672,324	0	672,324	90.02
91.00	09100	EMERGENCY	27,277,570		27,277,570	0	27,277,570	91.00
91.01	09101	SHORT STAY	0		0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,737,496		4,737,496		4,737,496	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	132,475		132,475	0	132,475	95.00
200.00		Subtotal (see instructions)	174,375,828	0	174,375,828	0	174,375,828	200.00
201.00		Less Observation Beds	4,737,496		4,737,496		4,737,496	201.00
202.00		Total (see instructions)	169,638,332	0	169,638,332	0	169,638,332	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/24/2022 5:25 pm

Title XIX | Hospital | Cost

		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	40,685,928		40,685,928			30.00
31.00	03100	INTENSIVE CARE UNIT	14,315,544		14,315,544			31.00
41.00	04100	SUBPROVIDER - IRF	6,620,772		6,620,772			41.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,788,344	82,568,404	99,356,748	0.140416	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,057,180	12,362,919	14,420,099	0.331443	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	123,459	9,797,425	9,920,884	0.202081	0.000000	55.00
57.00	05700	CT SCAN	4,552,542	18,736,469	23,289,011	0.023797	0.000000	57.00
57.01	03630	ULTRA SOUND	1,229,163	8,146,989	9,376,152	0.060548	0.000000	57.01
58.00	05800	MRI	695,065	6,447,646	7,142,711	0.071033	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,198,976	17,015,118	27,214,094	0.055590	0.000000	59.00
60.00	06000	LABORATORY	18,594,663	50,503,702	69,098,365	0.181832	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,242,612	546,277	1,788,889	0.525996	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	7,704,992	2,148,118	9,853,110	0.289156	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,833,651	23,450,272	31,283,923	0.289839	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,559,343	8,593,775	11,153,118	0.141534	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,134,512	28,749,474	46,883,986	0.238064	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,919,176	16,438,780	22,357,956	0.575755	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,024,653	45,377,274	63,401,927	0.295895	0.000000	73.00
74.00	07400	RENAL DIALYSIS	696,544	10,116	706,660	0.744120	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03140	CARDIAC REHAB	747,576	15,495,537	16,243,113	0.178963	0.000000	76.01
76.02	03070	WOMEN'S CENTER	13,836	7,757,630	7,771,466	0.198477	0.000000	76.02
76.03	03330	ENDOSCOPY	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	48,945	5,397,966	5,446,911	0.150305	0.000000	90.00
90.01	09001	OUTPATIENT	225,347	8,018,568	8,243,915	0.230222	0.000000	90.01
90.02	09002	NEUROPSYCHOLOGY	0	1,812,692	1,812,692	0.370898	0.000000	90.02
91.00	09100	EMERGENCY	4,853,922	52,000,991	56,854,913	0.479775	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0.000000	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,306,231	5,580,084	6,886,315	0.687958	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	185,172,976	426,956,226	612,129,202			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	185,172,976	426,956,226	612,129,202			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/24/2022 5:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
57.00	05700	CT SCAN	0.000000	57.00
57.01	03630	ULTRA SOUND	0.000000	57.01
58.00	05800	MRI	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0.000000	76.00
76.01	03140	CARDIAC REHAB	0.000000	76.01
76.02	03070	WOMEN'S CENTER	0.000000	76.02
76.03	03330	ENDOSCOPY	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	OUTPATIENT	0.000000	90.01
90.02	09002	NEUROPSYCHOLOGY	0.000000	90.02
91.00	09100	EMERGENCY	0.000000	91.00
91.01	09101	SHORT STAY	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0059

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

Worksheet D Part I

Date/Time Prepared: 5/24/2022 5:25 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	5,513,242	0	5,513,242	15,721	350.69	30.00
31.00	INTENSIVE CARE UNIT	847,485		847,485	4,199	201.83	31.00
41.00	SUBPROVIDER - IRF	956,367	0	956,367	4,301	222.36	41.00
43.00	NURSERY	0		0	1,512	0.00	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	7,317,094		7,317,094	25,733		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	3,853	1,351,209	30.00
31.00	INTENSIVE CARE UNIT	961	193,959	31.00
41.00	SUBPROVIDER - IRF	2,277	506,314	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	7,091	2,051,482	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/24/2022 5:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,690,104	99,356,748	0.027075	4,792,085	129,746	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	710,765	14,420,099	0.049290	708,117	34,903	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	378,844	9,920,884	0.038187	18,957	724	55.00
57.00	05700	CT SCAN	4,168	23,289,011	0.000179	1,460,932	262	57.00
57.01	03630	ULTRA SOUND	4,305	9,376,152	0.000459	287,551	132	57.01
58.00	05800	MRI	3,859	7,142,711	0.000540	167,428	90	58.00
59.00	05900	CARDIAC CATHETERIZATION	132,337	27,214,094	0.004863	2,946,228	14,328	59.00
60.00	06000	LABORATORY	828,437	69,098,365	0.011989	4,906,220	58,821	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	131,068	1,788,889	0.073268	224,199	16,427	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	95,743	9,853,110	0.009717	2,206,427	21,440	65.00
66.00	06600	PHYSICAL THERAPY	326,788	31,283,923	0.010446	1,143,907	11,949	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	350,914	11,153,118	0.031463	795,054	25,015	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	429,561	46,883,986	0.009162	4,664,331	42,735	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,671	22,357,956	0.003966	1,869,270	7,414	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	568,677	63,401,927	0.008969	4,180,801	37,498	73.00
74.00	07400	RENAL DIALYSIS	50,482	706,660	0.071437	181,314	12,953	74.00
76.00	03020	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	595,296	16,243,113	0.036649	160,125	5,868	76.01
76.02	03070	WOMEN'S CENTER	477,851	7,771,466	0.061488	2,049	126	76.02
76.03	03330	ENDOSCOPY	0	0	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	127,693	5,446,911	0.023443	5,309	124	90.00
90.01	09001	OUTPATIENT	193,388	8,243,915	0.023458	26,955	632	90.01
90.02	09002	NEUROPSYCHOLOGY	90,574	1,812,692	0.049967	0	0	90.02
91.00	09100	EMERGENCY	1,285,957	56,854,913	0.022618	1,925,544	43,552	91.00
91.01	09101	SHORT STAY	0	0	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	945,822	6,886,315	0.137348	412,169	56,611	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	10,511,304	550,506,958		33,084,972	521,350	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part III Date/Time Prepared: 5/24/2022 5:25 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	15,721	0.00	3,853	30.00
31.00	03100	INTENSIVE CARE UNIT		0	4,199	0.00	961	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	4,301	0.00	2,277	41.00
43.00	04300	NURSERY		0	1,512	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	25,733		7,091	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/24/2022 5:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	349,120	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	349,120	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/24/2022 5:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	99,356,748	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,420,099	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	9,920,884	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	23,289,011	0.000000	57.00
57.01	03630	ULTRA SOUND	0	0	0	9,376,152	0.000000	57.01
58.00	05800	MRI	0	0	0	7,142,711	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	27,214,094	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	69,098,365	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,788,889	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,853,110	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	31,283,923	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	11,153,118	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	46,883,986	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	22,357,956	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	349,120	349,120	63,401,927	0.005506	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	706,660	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03140	CARDIAC REHAB	0	0	0	16,243,113	0.000000	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	7,771,466	0.000000	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,446,911	0.000000	90.00
90.01	09001	OUTPATIENT	0	0	0	8,243,915	0.000000	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	1,812,692	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	56,854,913	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	6,886,315	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	349,120	349,120	550,506,958		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/24/2022 5:25 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						
50.00	05000	OPERATING ROOM	0.000000	4,792,085	0	18,804,153	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	708,117	0	2,170,619	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	18,957	0	2,696,349	0	55.00
57.00	05700	CT SCAN	0.000000	1,460,932	0	4,194,402	0	57.00
57.01	03630	ULTRA SOUND	0.000000	287,551	0	1,999,185	0	57.01
58.00	05800	MRI	0.000000	167,428	0	1,498,013	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	2,946,228	0	4,325,458	0	59.00
60.00	06000	LABORATORY	0.000000	4,906,220	0	3,990,064	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	224,199	0	63,096	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,206,427	0	729,371	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,143,907	0	174,229	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	795,054	0	1,735,638	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,664,331	0	6,196,031	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,869,270	0	4,595,102	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.005506	4,180,801	23,019	16,909,641	93,104	73.00
74.00	07400	RENAL DIALYSIS	0.000000	181,314	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0.000000	160,125	0	3,941,403	0	76.01
76.02	03070	WOMEN'S CENTER	0.000000	2,049	0	562,624	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	5,309	0	1,728,139	0	90.00
90.01	09001	OUTPATIENT	0.000000	26,955	0	2,308,611	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0.000000	0	0	1,026,813	0	90.02
91.00	09100	EMERGENCY	0.000000	1,925,544	0	5,862,049	0	91.00
91.01	09101	SHORT STAY	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	412,169	0	989,162	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		33,084,972	23,019	86,500,152	93,104	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/24/2022 5:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.140416	18,804,153	0	0	2,640,404	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.331443	2,170,619	0	0	719,436	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.202081	2,696,349	0	0	544,881	55.00
57.00	05700	CT SCAN	0.023797	4,194,402	0	0	99,814	57.00
57.01	03630	ULTRA SOUND	0.060548	1,999,185	0	0	121,047	57.01
58.00	05800	MRI	0.071033	1,498,013	0	0	106,408	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.055590	4,325,458	0	0	240,452	59.00
60.00	06000	LABORATORY	0.181832	3,990,064	0	0	725,521	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.525996	63,096	0	0	33,188	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.289156	729,371	0	0	210,902	65.00
66.00	06600	PHYSICAL THERAPY	0.289839	174,229	0	0	50,498	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.141534	1,735,638	0	0	245,652	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.238064	6,196,031	0	0	1,475,052	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.575755	4,595,102	0	0	2,645,653	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.295895	16,909,641	9,725	76,805	5,003,478	73.00
74.00	07400	RENAL DIALYSIS	0.744120	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0.178963	3,941,403	0	0	705,365	76.01
76.02	03070	WOMEN'S CENTER	0.198477	562,624	0	0	111,668	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.150305	1,728,139	0	0	259,748	90.00
90.01	09001	OUTPATIENT	0.230222	2,308,611	0	0	531,493	90.01
90.02	09002	NEUROPSYCHOLOGY	0.370898	1,026,813	0	0	380,843	90.02
91.00	09100	EMERGENCY	0.479775	5,862,049	0	0	2,812,465	91.00
91.01	09101	SHORT STAY	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.687958	989,162	0	0	680,502	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		86,500,152	9,725	76,805	20,344,470	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		86,500,152	9,725	76,805	20,344,470	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/24/2022 5:25 pm

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		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	57.01
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,878	22,726	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OUTPATIENT	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	90.02
91.00	09100	EMERGENCY	0	0	91.00
91.01	09101	SHORT STAY	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	2,878	22,726	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	2,878	22,726	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II | Date/Time Prepared: 5/24/2022 5:25 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,690,104	99,356,748	0.027075	182,109	4,931	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	710,765	14,420,099	0.049290	49,006	2,416	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	378,844	9,920,884	0.038187	30,927	1,181	55.00
57.00	05700	CT SCAN	4,168	23,289,011	0.000179	62,690	11	57.00
57.01	03630	ULTRA SOUND	4,305	9,376,152	0.000459	241,714	111	57.01
58.00	05800	MRI	3,859	7,142,711	0.000540	9,977	5	58.00
59.00	05900	CARDIAC CATHETERIZATION	132,337	27,214,094	0.004863	51,317	250	59.00
60.00	06000	LABORATORY	828,437	69,098,365	0.011989	522,961	6,270	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	131,068	1,788,889	0.073268	11,938	875	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	95,743	9,853,110	0.009717	257,997	2,507	65.00
66.00	06600	PHYSICAL THERAPY	326,788	31,283,923	0.010446	2,632,808	27,502	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	350,914	11,153,118	0.031463	21,981	692	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	429,561	46,883,986	0.009162	682,136	6,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,671	22,357,956	0.003966	66,293	263	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	568,677	63,401,927	0.008969	569,495	5,108	73.00
74.00	07400	RENAL DIALYSIS	50,482	706,660	0.071437	70,002	5,001	74.00
76.00	03020	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	595,296	16,243,113	0.036649	4,025	148	76.01
76.02	03070	WOMEN'S CENTER	477,851	7,771,466	0.061488	84	5	76.02
76.03	03330	ENDOSCOPY	0	0	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	127,693	5,446,911	0.023443	744	17	90.00
90.01	09001	OUTPATIENT	193,388	8,243,915	0.023458	8,745	205	90.01
90.02	09002	NEUROPSYCHOLOGY	90,574	1,812,692	0.049967	0	0	90.02
91.00	09100	EMERGENCY	1,285,957	56,854,913	0.022618	23,853	540	91.00
91.01	09101	SHORT STAY	0	0	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,886,315	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	9,565,482	550,506,958		5,500,802	64,288	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/24/2022 5:25 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	349,120	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	349,120	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/24/2022 5:25 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	99,356,748	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,420,099	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	9,920,884	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	23,289,011	0.000000	57.00
57.01	03630	ULTRA SOUND	0	0	0	9,376,152	0.000000	57.01
58.00	05800	MRI	0	0	0	7,142,711	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	27,214,094	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	69,098,365	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,788,889	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,853,110	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	31,283,923	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	11,153,118	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	46,883,986	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	22,357,956	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	349,120	349,120	63,401,927	0.005506	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	706,660	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03140	CARDIAC REHAB	0	0	0	16,243,113	0.000000	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	7,771,466	0.000000	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,446,911	0.000000	90.00
90.01	09001	OUTPATIENT	0	0	0	8,243,915	0.000000	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	1,812,692	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	56,854,913	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	6,886,315	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	349,120	349,120	550,506,958		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/24/2022 5:25 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	182,109	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	49,006	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	30,927	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	62,690	0	0	0	57.00
57.01	03630	ULTRA SOUND	0.000000	241,714	0	0	0	57.01
58.00	05800	MRI	0.000000	9,977	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	51,317	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	522,961	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	11,938	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	257,997	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,632,808	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	21,981	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	682,136	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	66,293	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.005506	569,495	3,136	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	70,002	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0.000000	4,025	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0.000000	84	0	0	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	744	0	0	0	90.00
90.01	09001	OUTPATIENT	0.000000	8,745	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	23,853	0	224	0	91.00
91.01	09101	SHORT STAY	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		5,500,802	3,136	224	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V | Date/Time Prepared: 5/24/2022 5:25 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.140416	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.331443	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.202081	0	0	0	0	55.00
57.00	05700	CT SCAN	0.023797	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0.060548	0	0	0	0	57.01
58.00	05800	MRI	0.071033	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.055590	0	0	0	0	59.00
60.00	06000	LABORATORY	0.181832	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.525996	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.289156	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.289839	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.141534	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.238064	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.575755	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.295895	0	0	436	0	73.00
74.00	07400	RENAL DIALYSIS	0.744120	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0.178963	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0.198477	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.150305	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0.230222	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0.370898	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.479775	224	0	0	107	91.00
91.01	09101	SHORT STAY	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.687958	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		224	0	436	107	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		224	0	436	107	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/24/2022 5:25 pm
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	57.01
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	129	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OUTPATIENT	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	90.02
91.00	09100	EMERGENCY	0	0	91.00
91.01	09101	SHORT STAY	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	129	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	129	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/24/2022 5:25 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)	15,721	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,721	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)	13,024	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	3,853	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)	27,615,134	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)	27,615,134	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)	27,615,134	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,756.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,768,103	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)	6,768,103	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/24/2022 5:25 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,199,310	4,199	1,714.53	961	1,647,663	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)	8,033,479	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	16,449,245	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,545,168	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	544,369	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,089,537	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	14,359,708	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)	2,697	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,756.58	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,737,496	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/24/2022 5:25 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	5,513,242	27,615,134	0.199646	4,737,496	945,822	90.00
91.00	Nursing Program cost	0	27,615,134	0.000000	4,737,496	0	91.00
92.00	Allied health cost	0	27,615,134	0.000000	4,737,496	0	92.00
93.00	All other Medical Education	0	27,615,134	0.000000	4,737,496	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/24/2022 5:25 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,301	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,301	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,301	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)	2,277	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,377,344	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,377,344	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,377,344	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,250.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,846,819	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,846,819	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/24/2022 5:25 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	1,445,393	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,292,212	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)	506,314	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	67,424	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	573,738	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,718,474	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: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/24/2022 5:25 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	956,367	5,377,344	0.177851	0	0	90.00
91.00	Nursing Program cost	0	5,377,344	0.000000	0	0	91.00
92.00	Allied health cost	0	5,377,344	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,377,344	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 Date/Time Prepared: 5/24/2022 5:25 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,721	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,721	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)	13,024	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)	375	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,512	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)	27,615,134	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)	27,615,134	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)	27,615,134	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,756.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	658,718	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)	658,718	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/24/2022 5:25 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	1,512	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,199,310	4,199	1,714.53	0	0	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)	317,340	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	976,058	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,697	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,756.58	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,737,496	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/24/2022 5:25 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	5,513,242	27,615,134	0.199646	4,737,496	945,822	90.00
91.00	Nursing Program cost	0	27,615,134	0.000000	4,737,496	0	91.00
92.00	Allied health cost	0	27,615,134	0.000000	4,737,496	0	92.00
93.00	All other Medical Education	0	27,615,134	0.000000	4,737,496	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/24/2022 5:25 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,301	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,301	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,301	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)	13	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,512	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,377,344	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,377,344	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,377,344	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,250.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	16,253	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)	16,253	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/24/2022 5:25 pm

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	10,740	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	26,993	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/24/2022 5:25 pm

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	956,367	5,377,344	0.177851	0	0	90.00
91.00	Nursing Program cost	0	5,377,344	0.000000	0	0	91.00
92.00	Allied health cost	0	5,377,344	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,377,344	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/24/2022 5:25 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		8,148,094		30.00
31.00	03100	INTENSIVE CARE UNIT		2,888,794		31.00
41.00	04100	SUBPROVIDER - IRF		1,374,611		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.140416	4,792,085	672,885	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.331443	708,117	234,700	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.202081	18,957	3,831	55.00
57.00	05700	CT SCAN	0.023797	1,460,932	34,766	57.00
57.01	03630	ULTRA SOUND	0.060548	287,551	17,411	57.01
58.00	05800	MRI	0.071033	167,428	11,893	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.055590	2,946,228	163,781	59.00
60.00	06000	LABORATORY	0.181832	4,906,220	892,108	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.525996	224,199	117,928	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.289156	2,206,427	638,002	65.00
66.00	06600	PHYSICAL THERAPY	0.289839	1,143,907	331,549	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.141534	795,054	112,527	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.238064	4,664,331	1,110,409	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.575755	1,869,270	1,076,242	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.295895	4,180,801	1,237,078	73.00
74.00	07400	RENAL DIALYSIS	0.744120	181,314	134,919	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.178963	160,125	28,656	76.01
76.02	03070	WOMEN'S CENTER	0.198477	2,049	407	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.150305	5,309	798	90.00
90.01	09001	OUTPATIENT	0.230222	26,955	6,206	90.01
90.02	09002	NEUROPSYCHOLOGY	0.370898	0	0	90.02
91.00	09100	EMERGENCY	0.479775	1,925,544	923,828	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.687958	412,169	283,555	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		33,084,972	8,033,479	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)		33,084,972		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/24/2022 5:25 pm
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF		3,376,970		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.140416	182,109	25,571	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.331443	49,006	16,243	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.202081	30,927	6,250	55.00
57.00	05700	CT SCAN	0.023797	62,690	1,492	57.00
57.01	03630	ULTRA SOUND	0.060548	241,714	14,635	57.01
58.00	05800	MRI	0.071033	9,977	709	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.055590	51,317	2,853	59.00
60.00	06000	LABORATORY	0.181832	522,961	95,091	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.525996	11,938	6,279	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.289156	257,997	74,601	65.00
66.00	06600	PHYSICAL THERAPY	0.289839	2,632,808	763,090	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.141534	21,981	3,111	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.238064	682,136	162,392	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.575755	66,293	38,169	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.295895	569,495	168,511	73.00
74.00	07400	RENAL DIALYSIS	0.744120	70,002	52,090	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.178963	4,025	720	76.01
76.02	03070	WOMEN'S CENTER	0.198477	84	17	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.150305	744	112	90.00
90.01	09001	OUTPATIENT	0.230222	8,745	2,013	90.01
90.02	09002	NEUROPSYCHOLOGY	0.370898	0	0	90.02
91.00	09100	EMERGENCY	0.479775	23,853	11,444	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.687958	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,500,802	1,445,393	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		5,500,802		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/24/2022 5:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		706,577		30.00
31.00	03100	INTENSIVE CARE UNIT		150,548		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.140416	259,815	36,482	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.331443	11,927	3,953	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.202081	0	0	55.00
57.00	05700	CT SCAN	0.023797	42,007	1,000	57.00
57.01	03630	ULTRA SOUND	0.060548	9,800	593	57.01
58.00	05800	MRI	0.071033	9,793	696	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.055590	66,463	3,695	59.00
60.00	06000	LABORATORY	0.181832	269,463	48,997	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.525996	34,984	18,401	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.289156	65,096	18,823	65.00
66.00	06600	PHYSICAL THERAPY	0.289839	39,436	11,430	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.141534	18,128	2,566	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.238064	232,562	55,365	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.575755	39,874	22,958	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.295895	208,360	61,653	73.00
74.00	07400	RENAL DIALYSIS	0.744120	2,288	1,703	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.178963	1,630	292	76.01
76.02	03070	WOMEN'S CENTER	0.198477	0	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.150305	47	7	90.00
90.01	09001	OUTPATIENT	0.230222	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0.370898	0	0	90.02
91.00	09100	EMERGENCY	0.479775	59,873	28,726	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.687958	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,371,546	317,340	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)		1,371,546		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/24/2022 5:25 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF		177,906		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.140416	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.331443	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.202081	0	0	55.00
57.00	05700	CT SCAN	0.023797	0	0	57.00
57.01	03630	ULTRA SOUND	0.060548	0	0	57.01
58.00	05800	MRI	0.071033	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.055590	0	0	59.00
60.00	06000	LABORATORY	0.181832	2,207	401	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.525996	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.289156	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.289839	17,751	5,145	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.141534	1,256	178	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.238064	21,069	5,016	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.575755	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.295895	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.744120	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.178963	0	0	76.01
76.02	03070	WOMEN'S CENTER	0.198477	0	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.150305	0	0	90.00
90.01	09001	OUTPATIENT	0.230222	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0.370898	0	0	90.02
91.00	09100	EMERGENCY	0.479775	0	0	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.687958	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		42,283	10,740	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)		42,283		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/24/2022 5:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	7,207,636	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,558,847	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	333,798	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	121,935	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	111.15	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1.18	30.00
31.00	Percentage of Medicaid patient days (see instructions)	19.60	31.00
32.00	Sum of lines 30 and 31	20.78	32.00
33.00	Allowable disproportionate share percentage (see instructions)	6.36	33.00
34.00	Disproportionate share adjustment (see instructions)	155,288	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/24/2022 5:25 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,682,889	1,478,064	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,258,708	372,553	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,631,261		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	12,008,765		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	12,008,765	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	916,191	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	20,610	53.00
54.00	Special add-on payments for new technologies	204,016	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	23,019	58.00
59.00	Total (sum of amounts on lines 49 through 58)	13,172,601	59.00
60.00	Primary payer payments	9,797	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	13,162,804	61.00
62.00	Deductibles billed to program beneficiaries	1,140,132	62.00
63.00	Coinsurance billed to program beneficiaries	17,066	63.00
64.00	Allowable bad debts (see instructions)	20,958	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	13,623	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	12,019,229	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	13,723	70.93
70.94	HRR adjustment amount (see instructions)	-9,545	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/24/2022 5:25 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		131,331	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,892,076	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		11,347,765	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		544,311	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		146,474	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 5/24/2022 5:25 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,207,636	0	7,207,636		7,207,636	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,558,847	0		2,558,847	2,558,847	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	333,798	0	333,798		333,798	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	121,935	0		121,935	121,935	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0636	0.0636	0.0636	0.0636		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	155,288	0	114,602	40,686	155,288	11.00
11.01	Uncompensated care payments	36.00	1,631,261	0	1,258,708	372,553	1,631,261	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	12,008,765	0	8,914,744	3,094,021	12,008,765	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,008,765	0	8,914,744	3,094,021	12,008,765	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	916,191	0	0	916,191	916,191	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/24/2022 5:25 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	204,016	0	0	204,016	204,016	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	8,914,744	4,214,228	13,128,972	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	741,471	0	0	741,471	741,471	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	142,837	0	0	142,837	142,837	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0430	0.0430	0.0430	0.0430		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	31,883	0	0	31,883	31,883	25.00
26.00	Total prospective capital payments (see instructions)	12.00	916,191	0	0	916,191	916,191	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/24/2022 5:25 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,207,636	7,207,636		7,207,636	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,558,847		2,558,847	2,558,847	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	333,798	333,798		333,798	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	121,935		121,935	121,935	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0636	0.0636	0.0636		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	155,288	114,602	40,686	155,288	11.00
11.01	Uncompensated care payments	36.00	1,631,261	1,258,708	372,553	1,631,261	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	12,008,765	8,914,744	3,094,021	12,008,765	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,008,765	8,914,744	3,094,021	12,008,765	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	916,191	683,247	232,944	916,191	16.00
17.00	Special add-on payments for new technologies	54.00	204,016	0	204,016	204,016	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			9,597,991	3,530,981	13,128,972	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/24/2022 5:25 pm
	Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	741,471	551,723	189,748	741,471	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	142,837	107,800	35,037	142,837	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0430	0.0430	0.0430		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	31,883	23,724	8,159	31,883	25.00
26.00	Total prospective capital payments (see instructions)	12.00	916,191	683,247	232,944	916,191	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	13,723	0	13,723	13,723	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-9,545	-5,884	-3,661	-9,545	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		95,921	35,410	131,331	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/24/2022 5:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	25,604	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	20,251,366	2.00
3.00	OPPS payments	17,048,261	3.00
4.00	Outlier payment (see instructions)	286,991	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	93,104	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	25,604	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	86,530	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)	86,530	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)	86,530	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	60,926	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)	25,604	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)	17,428,356	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,057,388	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)	14,396,572	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)	14,396,572	30.00
31.00	Primary payer payments	3,025	31.00
32.00	Subtotal (line 30 minus line 31)	14,393,547	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)	48,766	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	31,698	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	-261	36.00
37.00	Subtotal (see instructions)	14,425,245	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-141	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)	14,425,386	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	14,559,304	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)	-133,918	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/24/2022 5:25 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	129	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	107	2.00
3.00	OPPS payments	80	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)	129	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	436	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)	436	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)	436	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	307	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)	129	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)	80	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	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)	209	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)	209	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	209	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)	209	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)	209	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	254	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)	-45	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: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I Date/Time Prepared: 5/24/2022 5:25 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		11,215,341		14,301,502	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/31/2021	132,424	12/31/2021	257,802	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)		132,424		257,802	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)		11,347,765		14,559,304	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		544,311		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		133,918	6.02
7.00	Total Medicare program liability (see instructions)		11,892,076		14,425,386	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2022 5:25 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,348,710		254	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)		4,348,710		254	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		46,772		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		45	6.02
7.00	Total Medicare program liability (see instructions)		4,395,482		209	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: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/24/2022 5:25 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-3 Part III | Date/Time Prepared: 5/24/2022 5:25 pm

Title XVIII | Subprovider - IRF | PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	4,163,370	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0182	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	134,477	3.00
4.00	Outlier Payments	142,577	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	11.783562	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)	4,440,424	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)	4,440,424	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	4,440,424	19.00
20.00	Deductibles	35,464	20.00
21.00	Subtotal (line 19 minus line 20)	4,404,960	21.00
22.00	Coinsurance	12,614	22.00
23.00	Subtotal (line 21 minus line 22)	4,392,346	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)	4,392,346	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)	3,136	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)	4,395,482	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	4,348,710	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)	46,772	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	142,577	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2022 5:25 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	976,058		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)	976,058	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)	976,058	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	857,125		8.00
9.00	Ancillary service charges	1,371,546	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)	2,228,671	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)	2,228,671	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,252,613	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)	976,058	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)	976,058	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)	976,058	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)	976,058	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	976,058	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)	976,058	0	40.00
41.00	Interim payments	992,912	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-16,854	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2022 5:25 pm
	Title XIX	Subprovider - IRF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	26,993		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)	26,993	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)	26,993	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	177,906		8.00
9.00	Ancillary service charges	42,283	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)	220,189	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)	220,189	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	193,196	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)	26,993	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)	26,993	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)	26,993	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)	26,993	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	26,993	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)	26,993	0	40.00
41.00	Interim payments	81,719	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-54,726	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 5/24/2022 5:25 pm
	Title XVIII	Hospital	PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	0.00		17.00
18.00	Per resident amount	0.00	0.00		18.00
19.00	Approved amount for resident costs	0	0	0	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			0	25.00
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	7,091	4,793		26.00
27.00	Total Inpatient Days (see instructions)	21,783	21,783		27.00
28.00	Ratio of inpatient days to total inpatient days	0.325529	0.220034		28.00
29.00	Program direct GME amount	0	0	0	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	0	30.00
31.00	Net Program direct GME amount			0	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 5/24/2022 5:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	706,660	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	20,741,457	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	9,797	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	20,731,660	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	20,370,310	42.00
43.00	Primary payer payments (see instructions)	3,025	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	20,367,285	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	41,098,945	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.504433	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.495567	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	0	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	0	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	0	50.00

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

Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/24/2022 5:25 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	15,019,571	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	89,603,928	0	0	0	4.00
5.00	Other receivable	13,874,067	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-58,621,658	0	0	0	6.00
7.00	Inventory	6,202,782	0	0	0	7.00
8.00	Prepaid expenses	2,448,802	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	68,527,492	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	16,050,414	0	0	0	12.00
13.00	Land improvements	3,231,090	0	0	0	13.00
14.00	Accumulated depreciation	-4,139,492	0	0	0	14.00
15.00	Buildings	166,173,303	0	0	0	15.00
16.00	Accumulated depreciation	-82,061,686	0	0	0	16.00
17.00	Leasehold improvements	1,399,855	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	50,300,481	0	0	0	19.00
20.00	Accumulated depreciation	-36,449,806	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	122,055,242	0	0	0	23.00
24.00	Accumulated depreciation	-90,025,240	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	146,534,161	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	82,772,034	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	79,827	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	82,851,861	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	297,913,514	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	11,065,550	0	0	0	37.00
38.00	Salaries, wages, and fees payable	11,328,351	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	15,517,716	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	110,303,826	0	0	0	43.00
44.00	Other current liabilities	10,257,533	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	158,472,976	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	50,770,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,886,070	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	52,656,070	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	211,129,046	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	86,784,468				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)	86,784,468	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	297,913,514	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 | Date/Time Prepared: 5/24/2022 5:25 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		100,776,794		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-13,992,326				2.00
3.00	Total (sum of line 1 and line 2)		86,784,468		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)		86,784,468		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)		86,784,468		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: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/24/2022 5:25 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	51,900,501		51,900,501	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	7,522,180		7,522,180	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	59,422,681		59,422,681	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	17,049,477		17,049,477	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)	17,049,477		17,049,477	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	76,472,158		76,472,158	17.00
18.00	Ancillary services	108,534,540	347,382,737	455,917,277	18.00
19.00	Outpatient services	6,282,634	73,576,731	79,859,365	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER OUTPATIENT	0	46,244,458	46,244,458	27.00
27.01	PROF FEES	0	28,458,897	28,458,897	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	191,289,332	495,662,823	686,952,155	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		261,657,380		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)		261,657,380		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-3 | Date/Time Prepared: 5/24/2022 5:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	686,952,155	1.00
2.00	Less contractual allowances and discounts on patients' accounts	464,692,081	2.00
3.00	Net patient revenues (line 1 minus line 2)	222,260,074	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	261,657,380	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-39,397,306	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	10,296,260	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	13,160,988	24.00
24.01	OTHER OPERATING REVENUE	167,017	24.01
24.50	COVID-19 PHE Funding	1,780,715	24.50
25.00	Total other income (sum of lines 6-24)	25,404,980	25.00
26.00	Total (line 5 plus line 25)	-13,992,326	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)	-13,992,326	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 5/24/2022 5:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	741,471	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	142,837	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	47.90	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	1.18	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	19.60	8.00
9.00	Sum of lines 7 and 8	20.78	9.00
10.00	Allowable disproportionate share percentage (see instructions)	4.30	10.00
11.00	Disproportionate share adjustment (see instructions)	31,883	11.00
12.00	Total prospective capital payments (see instructions)	916,191	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00