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: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet S Parts I-III | Date/Time Prepared: 10/29/2021 5:12 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 10/29/2021 Time: 5:12 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

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 the Balance Sheet and Statement of Revenue and Expenses prepared by ST JOSEPH MEDICAL CENTER (15-0047) for the cost reporting period beginning 06/01/2020 and ending 05/31/2021 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.

[ ] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed)____________________
Officer or Administrator of Provider(s)

____
Title

____
Date

	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	524,636	-73,241	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	524,636	-73,241	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 10/29/2021 5:12 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 700 BROADWAY STREET	PO Box:			1.00
2.00	City: FORT WAYNE	State: IN	Zip Code: 46802	County: ALLEN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST JOSEPH MEDICAL CENTER	150047	23060	1	07/01/1996	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	06/01/2020	05/31/2021	20.00
21.00	Type of Control (see instructions)	4		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations 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.				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: 15-0047	Period: From 06/01/2020 To 05/31/2021	Worksheet S-2 Part I Date/Time Prepared: 10/29/2021 5:12 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.	1,070	120	53	8	4,113	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0047	Period: From 06/01/2020 To 05/31/2021	Worksheet S-2 Part I Date/Time Prepared: 10/29/2021 5:12 pm

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0047	Period: From 06/01/2020 To 05/31/2021	Worksheet S-2 Part I Date/Time Prepared: 10/29/2021 5:12 pm

			1.00	
	Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00
	TEFRA Providers			
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00
		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0047	Period: From 06/01/2020 To 05/31/2021	Worksheet S-2 Part I Date/Time Prepared: 10/29/2021 5:12 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	122,470	113,700	0	118.01

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

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

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	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

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	09/09/2021	Y	09/09/2021	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0047	Period: From 06/01/2020 To 05/31/2021	Worksheet S-2 Part II Date/Time Prepared: 10/29/2021 5:12 pm

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

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VICTORIA	ROMANKO	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 925-4333	VICTORIA_ROMANKO@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0047	Period: From 06/01/2020 To 05/31/2021	Worksheet S-2 Part II Date/Time Prepared: 10/29/2021 5:12 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, REVENUE MANAGEMENT		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: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet S-3 Part I Date/Time Prepared: 10/29/2021 5:12 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	61	22,265	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		61	22,265	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		61	22,265	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00	SUBPROVIDER - IRF						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)		61				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet S-3 Part I Date/Time Prepared: 10/29/2021 5:12 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)	1,355	1,070	9,766			1.00
2.00	HMO and other (see instructions)	1,057	4,294				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,355	1,070	9,766			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	0			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)	1,355	1,070	9,766	0.83	218.54	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF						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)			12			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)				0.83	218.54	27.00
28.00	Observation Bed Days		0	498			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			19			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 10/29/2021 5:12 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	234	1,239	2,053	1.00
2.00	HMO and other (see instructions)			213	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	234	1,239	2,053	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF						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: 15-0047	Period: From 06/01/2020 To 05/31/2021	Worksheet S-3 Part II Date/Time Prepared: 10/29/2021 5:12 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	15,310,237	0	15,310,237	454,558.00	33.68	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		80,322	0	80,322	1,046.00	76.79	11.00
12.00	Contract labor: Top level management and other management and administrative services		140,000	0	140,000	800.00	175.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		1,551,671	0	1,551,671	21,323.00	72.77	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		1,324,953	0	1,324,953	44,841.00	29.55	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)		3,209,440	0	3,209,440			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		0	0	0			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)		344,298	0	344,298			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

		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	175,940	0	175,940	4,222.00	41.67	26.00
27.00	Administrative & General	5.00	2,275,149	-378,072	1,897,077	67,446.00	28.13	27.00
28.00	Administrative & General under contract (see inst.)		303,760	0	303,760	709.00	428.43	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	948,519	0	948,519	37,942.00	25.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	481,237	0	481,237	26,921.00	17.88	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		512,032	0	512,032	24,959.00	20.51	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,120,784	378,072	1,498,856	29,053.00	51.59	38.00
39.00	Central Services and Supply	14.00	134,762	0	134,762	6,279.00	21.46	39.00
40.00	Pharmacy	15.00	649,571	0	649,571	12,089.00	53.73	40.00
41.00	Medical Records & Medical Records Library	16.00	58,443	0	58,443	2,873.00	20.34	41.00
42.00	Social Service	17.00	386,775	0	386,775	8,152.00	47.45	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

		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)		16,126,029	0	16,126,029	480,226.00	33.58	1.00
2.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		16,126,029	0	16,126,029	480,226.00	33.58	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,096,946	0	3,096,946	68,010.00	45.54	4.00
5.00	Subtotal wage-related costs (see inst.)		3,553,738	0	3,553,738	0.00	22.04	5.00
6.00	Total (sum of lines 3 thru 5)		22,776,713	0	22,776,713	548,236.00	41.55	6.00
7.00	Total overhead cost (see instructions)		7,046,972	0	7,046,972	220,645.00	31.94	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet S-3 Part IV Date/Time Prepared: 10/29/2021 5:12 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	307,452	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)	1,641,876	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	6,764	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	11,381	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	5,431	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	5,099	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	176,566	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	831,634	17.00
18.00	Medicare Taxes - Employers Portion Only	194,495	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	28,742	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,209,440	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: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet S-3 Part V Date/Time Prepared: 10/29/2021 5:12 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	80,322	3,209,440	1.00
2.00	Hospital	80,322	3,209,440	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			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: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet S-10 | Date/Time Prepared: 10/29/2021 5:12 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)	0.309103	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	11,434,073	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,466,941	5.00
6.00	Medicaid charges	82,888,507	6.00
7.00	Medicaid cost (line 1 times line 6)	25,621,086	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)	12,720,072	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)	12,720,072	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)	7,909,979	0	7,909,979	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,444,998	0	2,444,998	21.00
22.00	Payments received from patients for amounts previously written off as charity care	7,330	0	7,330	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,437,668	0	2,437,668	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)	8,080,260	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	141,831	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	218,201	27.01
28.00	Non-Medicare bad debt expense (see instructions)	7,862,059	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,506,556	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,944,224	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	17,664,296	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet A | Date/Time Prepared: 10/29/2021 5:12 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		6,376,398	6,376,398	1,490,104	7,866,502	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		9,020,715	9,020,715	605,271	9,625,986	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	175,940	56,124	232,064	2,157,143	2,389,207	4.00
5.01	00590	REVENUE CYCLE	666,946	4,809,750	5,476,696	-149,678	5,327,018	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	10,303	48,764	59,067	0	59,067	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	1,597,900	12,683,748	14,281,648	-3,970,009	10,311,639	5.03
7.00	00700	OPERATION OF PLANT	948,519	2,254,795	3,203,314	530,704	3,734,018	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	125,459	125,459	0	125,459	8.00
9.00	00900	HOUSEKEEPING	481,237	185,756	666,993	-1,139	665,854	9.00
10.00	01000	DIETARY	0	963,104	963,104	-222,415	740,689	10.00
11.00	01100	CAFETERIA	0	0	0	218,120	218,120	11.00
13.00	01300	NURSING ADMINISTRATION	1,120,784	114,009	1,234,793	377,881	1,612,674	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	134,762	386,700	521,462	-276,899	244,563	14.00
15.00	01500	PHARMACY	649,571	1,288,919	1,938,490	-1,092,373	846,117	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	58,443	269,002	327,445	-8,833	318,612	16.00
17.00	01700	SOCIAL SERVICE	386,775	57,349	444,124	-350	443,774	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,955,729	2,755,323	7,711,052	-3,949	7,707,103	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	95,105	149,229	244,334	-31,234	213,100	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	636,561	636,561	0	636,561	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	441,021	375,587	816,608	207,385	1,023,993	54.00
54.01	03630	ULTRA SOUND	176,208	77,585	253,793	-253,793	0	54.01
56.00	05600	RADIOISOTOPE	-463	5,739	5,276	-5,276	0	56.00
57.00	05700	CT SCAN	199,649	90,349	289,998	-289,998	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	42,033	365,411	407,444	-67,652	339,792	59.00
60.00	06000	LABORATORY	988,614	875,486	1,864,100	-55,443	1,808,657	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	38,597	38,597	0	38,597	62.00
65.00	06500	RESPIRATORY THERAPY	508,670	121,159	629,829	-2,756	627,073	65.00
66.00	06600	PHYSICAL THERAPY	84,930	8,513	93,443	-1,145	92,298	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,883	3,521	48,404	0	48,404	67.00
68.00	06800	SPEECH PATHOLOGY	12,854	1,359	14,213	0	14,213	68.00
69.00	06900	ELECTROCARDIOLOGY	53,877	5,588	59,465	0	59,465	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	21,893	21,893	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	25,715	25,715	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	800,230	800,230	73.00
74.00	07400	RENAL DIALYSIS	0	30,055	30,055	0	30,055	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	20,294	1,945	22,239	-11	22,228	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,865	836	7,701	0	7,701	90.00
91.00	09100	EMERGENCY	1,448,788	1,291,537	2,740,325	-1,493	2,738,832	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,310,237	45,474,972	60,785,209	0	60,785,209	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
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	15,310,237	45,474,972	60,785,209	0	60,785,209	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet A | Date/Time Prepared: 10/29/2021 5:12 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	-2,426,397	5,440,105	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-4,275,623	5,350,363	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,663	2,384,544	4.00
5.01	00590	REVENUE CYCLE	39,027	5,366,045	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	59,067	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	-942,496	9,369,143	5.03
7.00	00700	OPERATION OF PLANT	-15,367	3,718,651	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-41,522	83,937	8.00
9.00	00900	HOUSEKEEPING	0	665,854	9.00
10.00	01000	DIETARY	0	740,689	10.00
11.00	01100	CAFETERIA	0	218,120	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,612,674	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	244,563	14.00
15.00	01500	PHARMACY	0	846,117	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-28	318,584	16.00
17.00	01700	SOCIAL SERVICE	0	443,774	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	212,582	212,582	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,255,974	6,451,129	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-13,750	199,350	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	636,561	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,023,993	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	-45,144	294,648	59.00
60.00	06000	LABORATORY	-2,550	1,806,107	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	38,597	62.00
65.00	06500	RESPIRATORY THERAPY	0	627,073	65.00
66.00	06600	PHYSICAL THERAPY	0	92,298	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	48,404	67.00
68.00	06800	SPEECH PATHOLOGY	0	14,213	68.00
69.00	06900	ELECTROCARDIOLOGY	0	59,465	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	21,893	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,715	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	800,230	73.00
74.00	07400	RENAL DIALYSIS	0	30,055	74.00
76.00	03950	MISC ANCILLARY	0	0	76.00
76.01	03951	SLEEP LAB	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.02
76.03	03952	WOUND CARE	0	22,228	76.03
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	7,701	90.00
91.00	09100	EMERGENCY	-848,815	1,890,017	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
	SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,620,720	51,164,489	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,620,720	51,164,489	200.00

RECLASSIFICATIONS	Provider CCN: 15-0047	Period: From 06/01/2020 To 05/31/2021	Worksheet A-6 Date/Time Prepared: 10/29/2021 5:12 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,158,394	1.00
2.00		0.00	0	0	2.00
	0		0	2,158,394	
	C - LEASE AND RENTAL				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	594,843	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	112,074	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
	0		0	706,917	
	D - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	231,071	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,146,959	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	10,428	3.00
	0		0	1,388,458	
	E - REPAIRS & MAINTENANCE				
1.00	OPERATION OF PLANT	7.00	0	461,795	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
	0		0	461,795	
	F - CNO WAGES RECLASS				
1.00	NURSING ADMINISTRATION	13.00	378,072	0	1.00
	TOTALS		378,072	0	
	G - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	21,893	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	25,715	2.00
3.00	OPERATING ROOM	50.00	0	419	3.00
	0		0	48,027	
	H - DRUGS AND IV COSTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	800,230	1.00
	0		0	800,230	
	J - RADIOLOGY				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	375,394	28,925	1.00
2.00	RADIOISOTOPE	56.00	463	6,177	2.00
	0		375,857	35,102	
	K - DIETARY				
1.00	CAFETERIA	11.00	0	218,120	1.00
	0		0	218,120	
	M - UTILITIES RECLASS				
1.00	OPERATION OF PLANT	7.00	0	53,524	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	53,524	
	N - NON-CAPITALIZED EQUIPMENT				
1.00	OPERATION OF PLANT	7.00	0	15,816	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00

RECLASSIFICATIONS

Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet A-6 | Date/Time Prepared: 10/29/2021 5:12 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	TOTALS		0	15,816	
500.00	Grand Total: Increases		753,929	5,886,383	500.00

RECLASSIFICATIONS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet A-6 | Date/Time Prepared: 10/29/2021 5:12 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	2,158,373	0	1.00
2.00	REVENUE CYCLE	5.01	0	21	0	2.00
	0		0	2,158,394		
	C - LEASE AND RENTAL					
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	22,229	10	1.00
2.00	OPERATION OF PLANT	7.00	0	431	10	2.00
3.00	DIETARY	10.00	0	1,445	0	3.00
4.00	NURSING ADMINISTRATION	13.00	0	190	0	4.00
5.00	PHARMACY	15.00	0	292,143	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	173	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	145,706	0	7.00
8.00	LABORATORY	60.00	0	42,235	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	8,833	0	9.00
10.00	WOUND CARE	76.03	0	11	0	10.00
11.00	REVENUE CYCLE	5.01	0	295	0	11.00
12.00	CENTRAL SERVICES & SUPPLY	14.00	0	192,054	0	12.00
13.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,172	0	13.00
	0		0	706,917		
	D - OTHER CAPITAL COSTS					
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	1,388,458	12	1.00
2.00		0.00	0	0	13	2.00
3.00		0.00	0	0	12	3.00
	0		0	1,388,458		
	E - REPAIRS & MAINTENANCE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	79	0	1.00
2.00	REVENUE CYCLE	5.01	0	132,813	0	2.00
3.00	ADMINISTRATIVE AND GENERAL	5.03	0	17,926	0	3.00
4.00	HOUSEKEEPING	9.00	0	1,139	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	1	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	63,828	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	3,776	0	7.00
8.00	DIETARY	10.00	0	2,850	0	8.00
9.00	OPERATING ROOM	50.00	0	16,713	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	18,328	0	10.00
11.00	ULTRA SOUND	54.01	0	59,581	0	11.00
12.00	RADIOISOTOPE	56.00	0	11,916	0	12.00
13.00	CT SCAN	57.00	0	73,251	0	13.00
14.00	LABORATORY	60.00	0	13,208	0	14.00
15.00	RESPIRATORY THERAPY	65.00	0	1,880	0	15.00
16.00	PHYSICAL THERAPY	66.00	0	1,145	0	16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	41,518	0	17.00
18.00	SOCIAL SERVICE	17.00	0	350	0	18.00
19.00	EMERGENCY	91.00	0	1,493	0	19.00
	0		0	461,795		
	F - CNO WAGES RECLASS					
1.00	ADMINISTRATIVE AND GENERAL	5.03	378,072	0	0	1.00
	TOTALS		378,072	0		
	G - MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	21,017	0	1.00
2.00	RESPIRATORY THERAPY	65.00	0	876	0	2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	26,134	0	3.00
	0		0	48,027		
	H - DRUGS AND IV COSTS					
1.00	PHARMACY	15.00	0	800,230	0	1.00
	0		0	800,230		
	J - RADIOLOGY					
1.00	ULTRA SOUND	54.01	176,208	18,004	0	1.00
2.00	CT SCAN	57.00	199,649	17,098	0	2.00
	0		375,857	35,102		
	K - DIETARY					
1.00	DIETARY	10.00	0	218,120	0	1.00
	0		0	218,120		
	M - UTILITIES RECLASS					
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	4,626	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	32,900	0	2.00
3.00	REVENUE CYCLE	5.01	0	15,998	0	3.00
	0		0	53,524		
	N - NON-CAPITALIZED EQUIPMENT					
1.00	REVENUE CYCLE	5.01	0	551	0	1.00
2.00	ADMINISTRATIVE AND GENERAL	5.03	0	325	0	2.00
3.00	OPERATING ROOM	50.00	0	14,940	0	3.00
	TOTALS		0	15,816		
500.00	Grand Total: Decreases		753,929	5,886,383		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet A-7 Part I Date/Time Prepared: 10/29/2021 5:12 pm

		Beginning Balances	Acquisitions Purchases	Acquisitions Donation	Acquisitions Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	9,348,028	0	0	0	0	1.00
2.00	Land Improvements	1,775,835	0	0	0	0	2.00
3.00	Buildings and Fixtures	28,584,244	2,054	0	2,054	72,994	3.00
4.00	Building Improvements	31,942,549	66,398	0	66,398	78,064	4.00
5.00	Fixed Equipment	18,572,892	0	0	0	197,696	5.00
6.00	Movable Equipment	69,415,582	133,357	0	133,357	4,535,347	6.00
7.00	HIT designated Assets	2,833,813	21,867	0	21,867	0	7.00
8.00	Subtotal (sum of lines 1-7)	162,472,943	223,676	0	223,676	4,884,101	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	162,472,943	223,676	0	223,676	4,884,101	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	9,348,028	0	1.00
2.00	Land Improvements	1,775,835	0	2.00
3.00	Buildings and Fixtures	28,513,304	0	3.00
4.00	Building Improvements	31,930,883	0	4.00
5.00	Fixed Equipment	18,375,196	0	5.00
6.00	Movable Equipment	65,013,592	0	6.00
7.00	HIT designated Assets	2,855,680	0	7.00
8.00	Subtotal (sum of lines 1-7)	157,812,518	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	157,812,518	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet A-7 Part II | Date/Time Prepared: 10/29/2021 5:12 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	6,376,398	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,020,715	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	15,397,113	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	6,376,398	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9,020,715	2.00
3.00	Total (sum of lines 1-2)	0	15,397,113	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet A-7 Part III | Date/Time Prepared: 10/29/2021 5:12 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	71,568,049	0	71,568,049	0.453500	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	86,244,469	0	86,244,469	0.546500	0	2.00
3.00	Total (sum of lines 1-2)	157,812,518	0	157,812,518	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	2,882,280	112,074	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,756,608	583,327	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,638,888	695,401	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	1,067,721	231,071	1,146,959	0	5,440,105	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	10,428	0	0	5,350,363	2.00
3.00	Total (sum of lines 1-2)	1,067,721	241,499	1,146,959	0	10,790,468	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet A-8 | Date/Time Prepared: 10/29/2021 5:12 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-832	ADMINISTRATIVE AND GENERAL	5.03	0	7.00
8.00	Television and radio service (chapter 21)	A	-15,367	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,154,620			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	964,933			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-28	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines	B	-235	ADMINISTRATIVE AND GENERAL	5.03	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-3,558,379	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-4,405,243	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	A	-11,613	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet A-8 | Date/Time Prepared: 10/29/2021 5:12 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	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PARKING GARAGE & MISC INCOME	B	-14,935	ADMINISTRATIVE AND GENERAL	5.03	0	33.00
33.01	MARKETING & RECRUITING EXPENSE	A	-114,786	ADMINISTRATIVE AND GENERAL	5.03	0	33.01
33.02	PENALTIES	A	-72	ADMINISTRATIVE AND GENERAL	5.03	0	33.02
33.03	FITNESS REVENUE	B	-7,008	ADMINISTRATIVE AND GENERAL	5.03	0	33.03
33.04	SENIOR CIRCLE	A	-725	ADMINISTRATIVE AND GENERAL	5.03	0	33.04
33.05	SILVER RECOVERY	B	-3,462	ADMINISTRATIVE AND GENERAL	5.03	0	33.05
33.06	PATIENT PHONE WAGE COSTS	A	-8,412	ADMINISTRATIVE AND GENERAL	5.03	0	33.06
33.07	PATIENT PHONES BENEFITS	A	-1,763	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	PATIENT PHONE DEPRECIATION COST	A	-111	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09	PATIENT TV DEPRECIATION	A	-348	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.09
33.10	INTEREST INCOME ADD BACK	A	3,689	ADMINISTRATIVE AND GENERAL	5.03	0	33.10
33.11	PHYSICIAN RECRUITING	A	-2,900	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	LOBBYING EXPENSE IN DUES	A	-2,560	ADMINISTRATIVE AND GENERAL	5.03	0	33.12
33.13	CHARITABLE CONTRIBUTIONS	A	-79,061	ADMINISTRATIVE AND GENERAL	5.03	0	33.13
33.16	NONALLOWABLE LEGAL EXPENSES	A	-206,882	ADMINISTRATIVE AND GENERAL	5.03	0	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,620,720				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: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 10/29/2021 5:12 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	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL-RELATED INTEREST	1,067,721	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	3,577	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	438	0	3.00
4.00	5.01	REVENUE CYCLE	PASI OPERATING COSTS	303,572	264,545	4.00
4.01	5.03	ADMINISTRATIVE AND GENERAL	SHARED SERVICE CENTER ALLOCA	1,079,375	1,127,953	4.01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL-BLDG & FIXTURES	60,684	0	4.02
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL-MVBLE EQUIP	141,157	0	4.03
4.04	5.03	ADMINISTRATIVE AND GENERAL	NON-CAPITAL HOME OFFICE COST	1,520,094	0	4.04
4.05	5.03	ADMINISTRATIVE AND GENERAL	MALPRACTICE COSTS	236,170	452,690	4.05
4.06	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	208,544	220,060	4.06
4.07	5.03	ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	0	629,624	4.07
4.08	5.03	ADMINISTRATIVE AND GENERAL	401K FEES	0	5,774	4.08
4.09	5.03	ADMINISTRATIVE AND GENERAL	AUDIT FEES	0	44,014	4.09
4.10	5.03	ADMINISTRATIVE AND GENERAL	CORPORATE OVERHEAD ALLOCATIO	0	916,192	4.10
4.11	5.03	ADMINISTRATIVE AND GENERAL	HIIM ALLOCATION	0	152,987	4.11
4.12	5.03	ADMINISTRATIVE AND GENERAL	CONTRACT MANAGEMENT	0	4,152	4.12
4.13	5.03	ADMINISTRATIVE AND GENERAL	PASI LIEN UNIT COLLECTION FE	0	9,468	4.13
4.14	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICES	85,446	126,968	4.14
4.15	22.00	I&R SERVICES-OTHER PRGM COST	I&R COSTS BILLED BY THE FWME	212,582	0	4.15
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,919,360	3,954,427	5.00

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	CHS, INC	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00	C		33.00	SHARED LAUNDRY	33.00	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: 15-0047	Period: From 06/01/2020 To 05/31/2021	Worksheet A-8-1 Date/Time Prepared: 10/29/2021 5:12 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	1,067,721	11	1.00
2.00	3,577	9	2.00
3.00	438	9	3.00
4.00	39,027	0	4.00
4.01	-48,578	0	4.01
4.02	60,684	9	4.02
4.03	141,157	9	4.03
4.04	1,520,094	0	4.04
4.05	-216,520	0	4.05
4.06	-11,516	10	4.06
4.07	-629,624	0	4.07
4.08	-5,774	0	4.08
4.09	-44,014	0	4.09
4.10	-916,192	0	4.10
4.11	-152,987	0	4.11
4.12	-4,152	0	4.12
4.13	-9,468	0	4.13
4.14	-41,522	0	4.14
4.15	212,582	0	4.15
5.00	964,933		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	OWNER	6.00
7.00	DEBT COLLECTION	7.00
8.00	LAUNDRY	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: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 10/29/2021 5:12 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,244,361	1,244,361	0	0	0	1.00
2.00	50.00	OPERATING ROOM	13,750	13,750	0	0	0	2.00
3.00	59.00	CARDIAC CATHETERIZATION	45,144	45,144	0	0	0	3.00
4.00	60.00	LABORATORY	2,550	2,550	0	0	0	4.00
5.00	91.00	EMERGENCY	848,815	848,815	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,154,620	2,154,620	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,244,361	1.00
2.00	50.00	OPERATING ROOM	0	0	0	13,750	2.00
3.00	59.00	CARDIAC CATHETERIZATION	0	0	0	45,144	3.00
4.00	60.00	LABORATORY	0	0	0	2,550	4.00
5.00	91.00	EMERGENCY	0	0	0	848,815	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	2,154,620	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet B Part I Date/Time Prepared: 10/29/2021 5:12 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	REVENUE CYCLE	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,440,105	5,440,105				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,350,363		5,350,363			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,384,544	61,574	60,558	2,506,676		4.00
5.01	00590	REVENUE CYCLE	5,366,045	218,411	214,808	110,466	5,909,730	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	59,067	151,696	149,194	1,706	0	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	9,369,143	118,019	116,073	202,039	0	5.03
7.00	00700	OPERATION OF PLANT	3,718,651	2,077,416	2,043,146	157,102	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	83,937	48,343	47,545	0	0	8.00
9.00	00900	HOUSEKEEPING	665,854	731,917	719,843	79,707	0	9.00
10.00	01000	DIETARY	740,689	228,641	224,869	0	0	10.00
11.00	01100	CAFETERIA	218,120	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,612,674	83,768	82,387	248,254	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	244,563	0	0	22,320	0	14.00
15.00	01500	PHARMACY	846,117	0	0	107,588	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	318,584	137,004	134,744	9,680	0	16.00
17.00	01700	SOCIAL SERVICE	443,774	0	0	64,061	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	212,582	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,451,129	529,346	520,614	820,810	1,129,210	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	199,350	0	0	15,752	5,905	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	636,561	0	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,023,993	215,058	211,510	135,222	1,436,133	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	294,648	23,956	23,561	6,962	1,459	59.00
60.00	06000	LABORATORY	1,806,107	184,069	181,032	163,743	1,149,889	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	38,597	10,086	9,920	0	9,681	62.00
65.00	06500	RESPIRATORY THERAPY	627,073	74,791	73,558	84,251	215,659	65.00
66.00	06600	PHYSICAL THERAPY	92,298	97,182	95,579	14,067	15,890	66.00
67.00	06700	OCCUPATIONAL THERAPY	48,404	37,200	36,586	7,434	11,556	67.00
68.00	06800	SPEECH PATHOLOGY	14,213	14,327	14,090	2,129	1,640	68.00
69.00	06900	ELECTROCARDIOLOGY	59,465	13,635	13,410	8,924	64,436	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,893	0	0	0	19,888	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,715	0	0	0	1,573	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	800,230	32,229	31,697	0	654,894	73.00
74.00	07400	RENAL DIALYSIS	30,055	26,227	25,794	0	3,327	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	22,228	112,070	110,221	3,361	2,473	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,701	27,740	27,283	1,137	11,028	90.00
91.00	09100	EMERGENCY	1,890,017	172,195	169,354	239,961	1,174,989	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,164,489	5,426,900	5,337,376	2,506,676	5,909,730	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,205	12,987	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	51,164,489	5,440,105	5,350,363	2,506,676	5,909,730	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet B Part I Date/Time Prepared: 10/29/2021 5:12 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES	Subtotal	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	361,663					5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	12,885	9,818,159	9,818,159			5.03
7.00	00700	OPERATION OF PLANT	2,198	7,998,513	1,899,335	9,897,848		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,931	190,756	45,297	170,101	406,154	8.00
9.00	00900	HOUSEKEEPING	5,092	2,202,413	522,987	2,575,340	0	9.00
10.00	01000	DIETARY	63,472	1,257,671	298,648	804,501	0	10.00
11.00	01100	CAFETERIA	0	218,120	51,795	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	266	2,027,349	481,416	294,750	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,082	291,965	69,330	0	0	14.00
15.00	01500	PHARMACY	0	953,705	226,468	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28	600,040	142,486	482,067	0	16.00
17.00	01700	SOCIAL SERVICE	18	507,853	120,595	0	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	212,582	50,480	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,137	9,491,246	2,253,819	1,862,570	124,912	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,087	240,094	57,013	0	2,747	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	636,661	151,182	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,988	3,025,904	718,534	756,708	62,297	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	38,028	388,614	92,281	84,293	294	59.00
60.00	06000	LABORATORY	78,229	3,563,069	846,090	647,669	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,939	74,223	17,625	35,489	0	62.00
65.00	06500	RESPIRATORY THERAPY	6,479	1,081,811	256,888	263,163	0	65.00
66.00	06600	PHYSICAL THERAPY	5	315,021	74,805	341,946	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	141,180	33,525	130,893	0	67.00
68.00	06800	SPEECH PATHOLOGY	32	46,431	11,026	50,410	0	68.00
69.00	06900	ELECTROCARDIOLOGY	191	160,061	38,008	47,977	743	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,369	45,150	10,721	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,288	6,480	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,519,050	360,715	113,401	0	73.00
74.00	07400	RENAL DIALYSIS	10	85,413	20,282	92,281	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	75	250,428	59,467	394,331	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	48	74,937	17,795	97,607	0	90.00
91.00	09100	EMERGENCY	46,074	3,692,590	876,846	605,889	215,161	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	361,663	51,138,297	9,811,939	9,851,386	406,154	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,192	6,220	46,462	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	361,663	51,164,489	9,818,159	9,897,848	406,154	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet B Part I Date/Time Prepared: 10/29/2021 5:12 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	5,300,740					9.00
10.00	01000	DIETARY	596,226	2,957,046				10.00
11.00	01100	CAFETERIA	0	0	269,915			11.00
13.00	01300	NURSING ADMINISTRATION	218,443	0	23,029	3,044,987		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	5,366	0	366,661	14.00
15.00	01500	PHARMACY	0	0	10,324	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	357,266	0	2,452	0	42	16.00
17.00	01700	SOCIAL SERVICE	0	0	6,966	112,147	28	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,380,373	1,851,313	119,763	2,220,602	60,879	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	320	991	28,951	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	560,806	0	20,577	2,051	6,048	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	62,471	0	1,457	0	57,680	59.00
60.00	06000	LABORATORY	479,995	0	29,728	0	118,656	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	26,302	0	0	0	9,008	62.00
65.00	06500	RESPIRATORY THERAPY	195,033	0	12,581	0	9,828	65.00
66.00	06600	PHYSICAL THERAPY	253,421	0	1,404	0	7	66.00
67.00	06700	OCCUPATIONAL THERAPY	97,006	0	640	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	37,360	0	444	0	49	68.00
69.00	06900	ELECTROCARDIOLOGY	35,556	0	1,173	0	290	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	5,109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	84,043	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	68,391	0	0	0	15	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	292,244	0	409	0	114	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	72,338	0	178	0	73	90.00
91.00	09100	EMERGENCY	449,032	0	33,104	709,196	69,884	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,266,306	1,851,313	269,915	3,044,987	366,661	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	34,434	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	530,776	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	574,957	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,300,740	2,957,046	269,915	3,044,987	366,661	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet B Part I | Date/Time Prepared: 10/29/2021 5:12 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			15.00	16.00	17.00	22.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
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	1,190,497					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,584,353				16.00
17.00	01700	SOCIAL SERVICE	0	0	747,589			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	263,062		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	302,726	747,589	263,062	20,678,854	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,583	0	0	331,699	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	27	0	0	787,870	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	385,043	0	0	5,537,968	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	391	0	0	687,481	59.00
60.00	06000	LABORATORY	0	308,270	0	0	5,993,477	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,595	0	0	165,242	62.00
65.00	06500	RESPIRATORY THERAPY	0	57,815	0	0	1,877,119	65.00
66.00	06600	PHYSICAL THERAPY	0	4,260	0	0	990,864	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,098	0	0	406,342	67.00
68.00	06800	SPEECH PATHOLOGY	0	440	0	0	146,160	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,274	0	0	301,082	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,332	0	0	66,312	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	422	0	0	34,190	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,190,497	175,568	0	0	3,443,274	73.00
74.00	07400	RENAL DIALYSIS	0	892	0	0	267,274	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	663	0	0	997,656	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,956	0	0	265,884	90.00
91.00	09100	EMERGENCY	0	314,998	0	0	6,966,700	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,190,497	1,584,353	747,589	263,062	49,945,448	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	113,308	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	530,776	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	574,957	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,190,497	1,584,353	747,589	263,062	51,164,489	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet B Part I | Date/Time Prepared: 10/29/2021 5:12 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00590	REVENUE CYCLE			5.01
5.02	00560	PURCHASING RECEIVING AND STORES			5.02
5.03	00591	ADMINISTRATIVE AND GENERAL			5.03
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
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-263,062	20,415,792	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	331,699	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	787,870	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,537,968	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	687,481	59.00
60.00	06000	LABORATORY	0	5,993,477	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	165,242	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,877,119	65.00
66.00	06600	PHYSICAL THERAPY	0	990,864	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	406,342	67.00
68.00	06800	SPEECH PATHOLOGY	0	146,160	68.00
69.00	06900	ELECTROCARDIOLOGY	0	301,082	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	66,312	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	34,190	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,443,274	73.00
74.00	07400	RENAL DIALYSIS	0	267,274	74.00
76.00	03950	MISC ANCILLARY	0	0	76.00
76.01	03951	SLEEP LAB	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.02
76.03	03952	WOUND CARE	0	997,656	76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	265,884	90.00
91.00	09100	EMERGENCY	0	6,966,700	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-263,062	49,682,386	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	113,308	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	530,776	192.00
194.00	07950	MEALS ON WHEELS	0	574,957	194.00
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	-263,062	50,901,427	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet B Part II | Date/Time Prepared: 10/29/2021 5:12 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	61,574	60,558	122,132	122,132	4.00
5.01	00590	REVENUE CYCLE	0	218,411	214,808	433,219	5,382	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	151,696	149,194	300,890	83	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	0	118,019	116,073	234,092	9,844	5.03
7.00	00700	OPERATION OF PLANT	0	2,077,416	2,043,146	4,120,562	7,655	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	48,343	47,545	95,888	0	8.00
9.00	00900	HOUSEKEEPING	0	731,917	719,843	1,451,760	3,884	9.00
10.00	01000	DIETARY	0	228,641	224,869	453,510	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	83,768	82,387	166,155	12,096	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	1,088	14.00
15.00	01500	PHARMACY	0	0	0	0	5,242	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	137,004	134,744	271,748	472	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	3,121	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	529,346	520,614	1,049,960	39,991	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
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	0	767	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	215,058	211,510	426,568	6,588	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	23,956	23,561	47,517	339	59.00
60.00	06000	LABORATORY	0	184,069	181,032	365,101	7,978	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	10,086	9,920	20,006	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	74,791	73,558	148,349	4,105	65.00
66.00	06600	PHYSICAL THERAPY	0	97,182	95,579	192,761	685	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	37,200	36,586	73,786	362	67.00
68.00	06800	SPEECH PATHOLOGY	0	14,327	14,090	28,417	104	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,635	13,410	27,045	435	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	32,229	31,697	63,926	0	73.00
74.00	07400	RENAL DIALYSIS	0	26,227	25,794	52,021	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	112,070	110,221	222,291	164	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	27,740	27,283	55,023	55	90.00
91.00	09100	EMERGENCY	0	172,195	169,354	341,549	11,692	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,426,900	5,337,376	10,764,276	122,132	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,205	12,987	26,192	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
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	5,440,105	5,350,363	10,790,468	122,132	202.00

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		Cost Center Description	REVENUE CYCLE	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE	438,601					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	300,973				5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	0	10,722	254,658			5.03
7.00	00700	OPERATION OF PLANT	0	1,830	49,263	4,179,310		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,096	1,175	71,824	177,983	8.00
9.00	00900	HOUSEKEEPING	0	4,237	13,565	1,087,424	0	9.00
10.00	01000	DIETARY	0	52,820	7,746	339,696	0	10.00
11.00	01100	CAFETERIA	0	0	1,343	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	222	12,486	124,456	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20,873	1,798	0	0	14.00
15.00	01500	PHARMACY	0	0	5,874	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23	3,696	203,550	0	16.00
17.00	01700	SOCIAL SERVICE	0	15	3,128	0	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	1,309	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	83,812	33,401	58,462	786,459	54,738	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	438	15,884	1,479	0	1,204	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	7	0	3,921	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	106,560	3,318	18,637	319,516	27,300	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	108	31,646	2,393	35,592	129	59.00
60.00	06000	LABORATORY	85,347	65,106	21,945	273,474	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	719	4,942	457	14,985	0	62.00
65.00	06500	RESPIRATORY THERAPY	16,007	5,392	6,663	111,119	0	65.00
66.00	06600	PHYSICAL THERAPY	1,179	4	1,940	144,385	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	858	0	870	55,269	0	67.00
68.00	06800	SPEECH PATHOLOGY	122	27	286	21,286	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,783	159	986	20,258	326	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,476	2,803	278	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	117	0	168	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,608	0	9,356	47,883	0	73.00
74.00	07400	RENAL DIALYSIS	247	8	526	38,965	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	184	63	1,542	166,504	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	819	40	462	41,214	0	90.00
91.00	09100	EMERGENCY	87,210	38,342	22,743	255,833	94,286	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	438,601	300,973	254,497	4,159,692	177,983	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	161	19,618	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	438,601	300,973	254,658	4,179,310	177,983	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet B Part II | Date/Time Prepared: 10/29/2021 5:12 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	2,560,870					9.00
10.00	01000	DIETARY	288,046	1,141,818				10.00
11.00	01100	CAFETERIA	0	0	1,343			11.00
13.00	01300	NURSING ADMINISTRATION	105,533	0	115	421,063		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	27	0	23,786	14.00
15.00	01500	PHARMACY	0	0	51	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	172,601	0	12	0	3	16.00
17.00	01700	SOCIAL SERVICE	0	0	35	15,508	2	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	666,880	714,856	595	307,066	3,949	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	2	137	1,878	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	270,934	0	102	284	392	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	30,180	0	7	0	3,742	59.00
60.00	06000	LABORATORY	231,893	0	148	0	7,699	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	12,707	0	0	0	584	62.00
65.00	06500	RESPIRATORY THERAPY	94,224	0	63	0	638	65.00
66.00	06600	PHYSICAL THERAPY	122,432	0	7	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	46,865	0	3	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,049	0	2	0	3	68.00
69.00	06900	ELECTROCARDIOLOGY	17,178	0	6	0	19	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	331	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,602	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	33,041	0	0	0	1	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	141,187	0	2	0	7	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	34,948	0	1	0	5	90.00
91.00	09100	EMERGENCY	216,935	0	165	98,068	4,533	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,544,235	714,856	1,343	421,063	23,786	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,635	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	204,951	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	222,011	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,560,870	1,141,818	1,343	421,063	23,786	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet B Part II Date/Time Prepared: 10/29/2021 5:12 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			15.00	16.00	17.00	22.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
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	11,167					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	652,105				16.00
17.00	01700	SOCIAL SERVICE	0	0	21,809			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	1,309		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	124,598	21,809		3,946,576	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0		0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	652	0		22,441	50.00
51.00	05100	RECOVERY ROOM	0	0	0		0	51.00
53.00	05300	ANESTHESIOLOGY	0	11	0		3,939	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	158,486	0		1,338,685	54.00
54.01	03630	ULTRA SOUND	0	0	0		0	54.01
56.00	05600	RADIOISOTOPE	0	0	0		0	56.00
57.00	05700	CT SCAN	0	0	0		0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	161	0		151,814	59.00
60.00	06000	LABORATORY	0	126,879	0		1,185,570	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,068	0		55,468	62.00
65.00	06500	RESPIRATORY THERAPY	0	23,796	0		410,356	65.00
66.00	06600	PHYSICAL THERAPY	0	1,753	0		465,146	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,275	0		179,288	67.00
68.00	06800	SPEECH PATHOLOGY	0	181	0		68,477	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,110	0		78,305	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,194	0		7,082	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	174	0		459	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,167	72,261	0		293,803	73.00
74.00	07400	RENAL DIALYSIS	0	367	0		125,176	74.00
76.00	03950	MISC ANCILLARY	0	0	0		0	76.00
76.01	03951	SLEEP LAB	0	0	0		0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		0	76.02
76.03	03952	WOUND CARE	0	273	0		532,217	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,217	0		133,784	90.00
91.00	09100	EMERGENCY	0	129,649	0		1,301,005	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,167	652,105	21,809	0	10,299,591	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		62,606	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		204,951	192.00
194.00	07950	MEALS ON WHEELS	0	0	0		222,011	194.00
200.00		Cross Foot Adjustments				1,309	1,309	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,167	652,105	21,809	1,309	10,790,468	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet B Part II | Date/Time Prepared: 10/29/2021 5:12 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00590	REVENUE CYCLE			5.01
5.02	00560	PURCHASING RECEIVING AND STORES			5.02
5.03	00591	ADMINISTRATIVE AND GENERAL			5.03
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
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	3,946,576	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	22,441	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	3,939	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,338,685	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	151,814	59.00
60.00	06000	LABORATORY	0	1,185,570	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	55,468	62.00
65.00	06500	RESPIRATORY THERAPY	0	410,356	65.00
66.00	06600	PHYSICAL THERAPY	0	465,146	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	179,288	67.00
68.00	06800	SPEECH PATHOLOGY	0	68,477	68.00
69.00	06900	ELECTROCARDIOLOGY	0	78,305	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,082	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	459	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	293,803	73.00
74.00	07400	RENAL DIALYSIS	0	125,176	74.00
76.00	03950	MISC ANCILLARY	0	0	76.00
76.01	03951	SLEEP LAB	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.02
76.03	03952	WOUND CARE	0	532,217	76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	133,784	90.00
91.00	09100	EMERGENCY	0	1,301,005	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	10,299,591	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	62,606	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	204,951	192.00
194.00	07950	MEALS ON WHEELS	0	222,011	194.00
200.00		Cross Foot Adjustments	0	1,309	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	10,790,468	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet B-1 | Date/Time Prepared: 10/29/2021 5:12 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FOO TAGE)	MVBLE EQUIP (SQUARE FOO TAGE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	REVENUE CYCLE (GROSS CHAR GES)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	416,929					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		416,929				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,719	4,719	15,134,297			4.00
5.01	00590	REVENUE CYCLE	16,739	16,739	666,946	160,730,630		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	11,626	11,626	10,303	0	2,350,464	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	9,045	9,045	1,219,828	0	83,738	5.03
7.00	00700	OPERATION OF PLANT	159,213	159,213	948,519	0	14,288	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,705	3,705	0	0	71,038	8.00
9.00	00900	HOUSEKEEPING	56,094	56,094	481,237	0	33,093	9.00
10.00	01000	DIETARY	17,523	17,523	0	0	412,505	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,420	6,420	1,498,856	0	1,731	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	134,762	0	163,012	14.00
15.00	01500	PHARMACY	0	0	649,571	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,500	10,500	58,443	0	180	16.00
17.00	01700	SOCIAL SERVICE	0	0	386,775	0	120	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,569	40,569	4,955,729	30,711,755	260,851	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	95,105	160,598	124,047	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,732	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,482	16,482	816,415	39,059,699	25,916	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	1,836	1,836	42,033	39,668	247,144	59.00
60.00	06000	LABORATORY	14,107	14,107	988,614	31,274,181	508,417	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	773	773	0	263,308	38,597	62.00
65.00	06500	RESPIRATORY THERAPY	5,732	5,732	508,670	5,865,404	42,109	65.00
66.00	06600	PHYSICAL THERAPY	7,448	7,448	84,930	432,178	31	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,851	2,851	44,883	314,290	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,098	1,098	12,854	44,599	208	68.00
69.00	06900	ELECTROCARDIOLOGY	1,045	1,045	53,877	1,752,492	1,242	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	540,900	21,893	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	42,778	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,470	2,470	0	17,811,533	0	73.00
74.00	07400	RENAL DIALYSIS	2,010	2,010	0	90,483	64	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	8,589	8,589	20,294	67,272	489	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,126	2,126	6,865	299,932	314	90.00
91.00	09100	EMERGENCY	13,197	13,197	1,448,788	31,956,828	299,437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	415,917	415,917	15,134,297	160,730,630	2,350,464	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,012	1,012	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,440,105	5,350,363	2,506,676	5,909,730	361,663	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.048037	12.832792	0.165629	0.036768	0.153869	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			122,132	438,601	300,973	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.008070	0.002729	0.128048	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet B-1 | Date/Time Prepared: 10/29/2021 5:12 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FOOTAGE)	MVBLE EQUIP (SQUARE FOOTAGE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	REVENUE CYCLE (GROSS CHARGES)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
			1.00	2.00	4.00	5.01	5.02	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet B-1 | Date/Time Prepared: 10/29/2021 5:12 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM.COST)	OPERATION OF PLANT (SQUARE FOOTAGE)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FOOTAGE)	
			5A.03	5.03	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	-9,818,159	41,346,330				5.03
7.00	00700	OPERATION OF PLANT	0	7,998,513	215,587			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	190,756	3,705	135,595		8.00
9.00	00900	HOUSEKEEPING	0	2,202,413	56,094	0	155,788	9.00
10.00	01000	DIETARY	0	1,257,671	17,523	0	17,523	10.00
11.00	01100	CAFETERIA	0	218,120	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,027,349	6,420	0	6,420	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	291,965	0	0	0	14.00
15.00	01500	PHARMACY	0	953,705	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	600,040	10,500	0	10,500	16.00
17.00	01700	SOCIAL SERVICE	0	507,853	0	0	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	212,582	0	0	0	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	9,491,246	40,569	41,702	40,569	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	240,094	0	917	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	636,661	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,025,904	16,482	20,798	16,482	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	388,614	1,836	98	1,836	59.00
60.00	06000	LABORATORY	0	3,563,069	14,107	0	14,107	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	74,223	773	0	773	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,081,811	5,732	0	5,732	65.00
66.00	06600	PHYSICAL THERAPY	0	315,021	7,448	0	7,448	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	141,180	2,851	0	2,851	67.00
68.00	06800	SPEECH PATHOLOGY	0	46,431	1,098	0	1,098	68.00
69.00	06900	ELECTROCARDIOLOGY	0	160,061	1,045	248	1,045	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	45,150	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,288	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,519,050	2,470	0	2,470	73.00
74.00	07400	RENAL DIALYSIS	0	85,413	2,010	0	2,010	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	250,428	8,589	0	8,589	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	74,937	2,126	0	2,126	90.00
91.00	09100	EMERGENCY	0	3,692,590	13,197	71,832	13,197	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,818,159	41,320,138	214,575	135,595	154,776	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,192	1,012	0	1,012	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		9,818,159	9,897,848	406,154	5,300,740	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.237461	45.911154	2.995346	34.025342	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		254,658	4,179,310	177,983	2,560,870	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.006159	19.385724	1.312607	16.438172	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: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet B-1 | Date/Time Prepared: 10/29/2021 5:12 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (GROSS SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
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	77,105					10.00
11.00	01100	CAFETERIA	0	15,190				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,296	4,751,618			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	302	0	1,571,059		14.00
15.00	01500	PHARMACY	0	581	0	0	892,281	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	138	0	180	0	16.00
17.00	01700	SOCIAL SERVICE	0	392	175,002	120	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,273	6,740	3,465,189	260,851	0	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	18	1,547	124,047	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,158	3,200	25,916	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	82	0	247,144	0	59.00
60.00	06000	LABORATORY	0	1,673	0	508,417	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	38,597	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	708	0	42,109	0	65.00
66.00	06600	PHYSICAL THERAPY	0	79	0	31	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	36	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	25	0	208	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	66	0	1,242	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	21,893	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	892,281	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	64	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	23	0	489	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	10	0	314	0	90.00
91.00	09100	EMERGENCY	0	1,863	1,106,680	299,437	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,273	15,190	4,751,618	1,571,059	892,281	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	13,840	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	14,992	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,957,046	269,915	3,044,987	366,661	1,190,497	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	38.350898	17.769256	0.640832	0.233385	1.334218	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,141,818	1,343	421,063	23,786	11,167	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	14.808612	0.088413	0.088615	0.015140	0.012515	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: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet B-1 | Date/Time Prepared: 10/29/2021 5:12 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ROTATIONS)		
			16.00	17.00	22.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	REVENUE CYCLE					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00591	ADMINISTRATIVE AND GENERAL					5.03
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	160,730,630				16.00
17.00	01700	SOCIAL SERVICE	0	9,766			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	100		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	30,711,755	9,766	100		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0		33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	160,598	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	2,732	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,059,699	0	0		54.00
54.01	03630	ULTRA SOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
59.00	05900	CARDIAC CATHETERIZATION	39,668	0	0		59.00
60.00	06000	LABORATORY	31,274,181	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	263,308	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	5,865,404	0	0		65.00
66.00	06600	PHYSICAL THERAPY	432,178	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	314,290	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	44,599	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	1,752,492	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	540,900	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,778	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,811,533	0	0		73.00
74.00	07400	RENAL DIALYSIS	90,483	0	0		74.00
76.00	03950	MISC ANCILLARY	0	0	0		76.00
76.01	03951	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03952	WOUND CARE	67,272	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	299,932	0	0		90.00
91.00	09100	EMERGENCY	31,956,828	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	160,730,630	9,766	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	MEALS ON WHEELS	0	0	0		194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,584,353	747,589	263,062		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.009857	76.550174	2,630.620000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	652,105	21,809	1,309		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.004057	2.233156	13.090000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet B-1 | Date/Time Prepared: 10/29/2021 5:12 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ROTATIONS)	
			16.00	17.00	22.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet C Part I Date/Time Prepared: 10/29/2021 5:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,415,792		20,415,792	0	20,415,792	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	331,699		331,699	0	331,699	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	787,870		787,870	0	787,870	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,537,968		5,537,968	0	5,537,968	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	687,481		687,481	0	687,481	59.00
60.00	06000	LABORATORY	5,993,477		5,993,477	0	5,993,477	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	165,242		165,242	0	165,242	62.00
65.00	06500	RESPIRATORY THERAPY	1,877,119	0	1,877,119	0	1,877,119	65.00
66.00	06600	PHYSICAL THERAPY	990,864	0	990,864	0	990,864	66.00
67.00	06700	OCCUPATIONAL THERAPY	406,342	0	406,342	0	406,342	67.00
68.00	06800	SPEECH PATHOLOGY	146,160	0	146,160	0	146,160	68.00
69.00	06900	ELECTROCARDIOLOGY	301,082		301,082	0	301,082	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	66,312		66,312	0	66,312	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,190		34,190	0	34,190	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,443,274		3,443,274	0	3,443,274	73.00
74.00	07400	RENAL DIALYSIS	267,274		267,274	0	267,274	74.00
76.00	03950	MISC ANCILLARY	0		0	0	0	76.00
76.01	03951	SLEEP LAB	0		0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		0	0	0	76.02
76.03	03952	WOUND CARE	997,656		997,656	0	997,656	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	265,884		265,884	0	265,884	90.00
91.00	09100	EMERGENCY	6,966,700		6,966,700	0	6,966,700	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	990,557		990,557		990,557	92.00
200.00		Subtotal (see instructions)	50,672,943	0	50,672,943	0	50,672,943	200.00
201.00		Less Observation Beds	990,557		990,557		990,557	201.00
202.00		Total (see instructions)	49,682,386	0	49,682,386	0	49,682,386	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet C Part I Date/Time Prepared: 10/29/2021 5:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,998,295		28,998,295			30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	113,736	46,862	160,598	2.065399	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	2,732	0	2,732	288.385798	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,589,883	33,469,816	39,059,699	0.141782	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	3,942	35,726	39,668	17.330871	0.000000	59.00
60.00	06000	LABORATORY	8,685,259	22,588,922	31,274,181	0.191643	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	137,614	125,694	263,308	0.627562	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	5,052,369	813,035	5,865,404	0.320032	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	397,375	34,803	432,178	2.292722	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	288,348	25,942	314,290	1.292889	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	44,599	0	44,599	3.277204	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	419,565	1,332,927	1,752,492	0.171802	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	505,789	35,111	540,900	0.122596	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,778	0	42,778	0.799243	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,019,964	5,791,569	17,811,533	0.193317	0.000000	73.00
74.00	07400	RENAL DIALYSIS	84,528	5,955	90,483	2.953859	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	0.000000	76.02
76.03	03952	WOUND CARE	405	66,867	67,272	14.830182	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	28,038	271,894	299,932	0.886481	0.000000	90.00
91.00	09100	EMERGENCY	4,177,979	27,778,849	31,956,828	0.218003	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	548,759	1,164,701	1,713,460	0.578103	0.000000	92.00
200.00		Subtotal (see instructions)	67,141,957	93,588,673	160,730,630			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	67,141,957	93,588,673	160,730,630			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet C Part I Date/Time Prepared: 10/29/2021 5:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		33.00
40.00	04000	SUBPROVIDER - IPF		40.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	2.065399	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	288.385798	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141782	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	17.330871	59.00
60.00	06000	LABORATORY	0.191643	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.627562	62.00
65.00	06500	RESPIRATORY THERAPY	0.320032	65.00
66.00	06600	PHYSICAL THERAPY	2.292722	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.292889	67.00
68.00	06800	SPEECH PATHOLOGY	3.277204	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171802	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.122596	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.799243	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.193317	73.00
74.00	07400	RENAL DIALYSIS	2.953859	74.00
76.00	03950	MISC ANCILLARY	0.000000	76.00
76.01	03951	SLEEP LAB	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	76.02
76.03	03952	WOUND CARE	14.830182	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.886481	90.00
91.00	09100	EMERGENCY	0.218003	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.578103	92.00
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: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet C Part I Date/Time Prepared: 10/29/2021 5:12 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,415,792		20,415,792	0	20,415,792	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	331,699		331,699	0	331,699	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	787,870		787,870	0	787,870	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,537,968		5,537,968	0	5,537,968	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	687,481		687,481	0	687,481	59.00
60.00	06000	LABORATORY	5,993,477		5,993,477	0	5,993,477	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	165,242		165,242	0	165,242	62.00
65.00	06500	RESPIRATORY THERAPY	1,877,119	0	1,877,119	0	1,877,119	65.00
66.00	06600	PHYSICAL THERAPY	990,864	0	990,864	0	990,864	66.00
67.00	06700	OCCUPATIONAL THERAPY	406,342	0	406,342	0	406,342	67.00
68.00	06800	SPEECH PATHOLOGY	146,160	0	146,160	0	146,160	68.00
69.00	06900	ELECTROCARDIOLOGY	301,082		301,082	0	301,082	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	66,312		66,312	0	66,312	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,190		34,190	0	34,190	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,443,274		3,443,274	0	3,443,274	73.00
74.00	07400	RENAL DIALYSIS	267,274		267,274	0	267,274	74.00
76.00	03950	MISC ANCILLARY	0		0	0	0	76.00
76.01	03951	SLEEP LAB	0		0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		0	0	0	76.02
76.03	03952	WOUND CARE	997,656		997,656	0	997,656	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	265,884		265,884	0	265,884	90.00
91.00	09100	EMERGENCY	6,966,700		6,966,700	0	6,966,700	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	990,557		990,557		990,557	92.00
200.00		Subtotal (see instructions)	50,672,943	0	50,672,943	0	50,672,943	200.00
201.00		Less Observation Beds	990,557		990,557		990,557	201.00
202.00		Total (see instructions)	49,682,386	0	49,682,386	0	49,682,386	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet C Part I | Date/Time Prepared: 10/29/2021 5:12 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges					
			Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,998,295		28,998,295			30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	113,736	46,862	160,598	2.065399	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	2,732	0	2,732	288.385798	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,589,883	33,469,816	39,059,699	0.141782	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	3,942	35,726	39,668	17.330871	0.000000	59.00
60.00	06000	LABORATORY	8,685,259	22,588,922	31,274,181	0.191643	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	137,614	125,694	263,308	0.627562	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	5,052,369	813,035	5,865,404	0.320032	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	397,375	34,803	432,178	2.292722	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	288,348	25,942	314,290	1.292889	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	44,599	0	44,599	3.277204	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	419,565	1,332,927	1,752,492	0.171802	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	505,789	35,111	540,900	0.122596	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,778	0	42,778	0.799243	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,019,964	5,791,569	17,811,533	0.193317	0.000000	73.00
74.00	07400	RENAL DIALYSIS	84,528	5,955	90,483	2.953859	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	0.000000	76.02
76.03	03952	WOUND CARE	405	66,867	67,272	14.830182	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	28,038	271,894	299,932	0.886481	0.000000	90.00
91.00	09100	EMERGENCY	4,177,979	27,778,849	31,956,828	0.218003	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	548,759	1,164,701	1,713,460	0.578103	0.000000	92.00
200.00		Subtotal (see instructions)	67,141,957	93,588,673	160,730,630			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	67,141,957	93,588,673	160,730,630			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet C Part I | Date/Time Prepared: 10/29/2021 5:12 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		33.00
40.00	04000	SUBPROVIDER - IPF		40.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	2.065399	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	288.385798	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141782	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	17.330871	59.00
60.00	06000	LABORATORY	0.191643	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.627562	62.00
65.00	06500	RESPIRATORY THERAPY	0.320032	65.00
66.00	06600	PHYSICAL THERAPY	2.292722	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.292889	67.00
68.00	06800	SPEECH PATHOLOGY	3.277204	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171802	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.122596	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.799243	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.193317	73.00
74.00	07400	RENAL DIALYSIS	2.953859	74.00
76.00	03950	MISC ANCILLARY	0.000000	76.00
76.01	03951	SLEEP LAB	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	76.02
76.03	03952	WOUND CARE	14.830182	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.886481	90.00
91.00	09100	EMERGENCY	0.218003	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.578103	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet C Part II | Date/Time Prepared: 10/29/2021 5:12 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	331,699	22,441	309,258	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	787,870	3,939	783,931	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,537,968	1,338,685	4,199,283	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	687,481	151,814	535,667	0	0	59.00
60.00	06000	LABORATORY	5,993,477	1,185,570	4,807,907	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	165,242	55,468	109,774	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,877,119	410,356	1,466,763	0	0	65.00
66.00	06600	PHYSICAL THERAPY	990,864	465,146	525,718	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	406,342	179,288	227,054	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	146,160	68,477	77,683	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	301,082	78,305	222,777	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	66,312	7,082	59,230	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,190	459	33,731	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,443,274	293,803	3,149,471	0	0	73.00
74.00	07400	RENAL DIALYSIS	267,274	125,176	142,098	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	997,656	532,217	465,439	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	265,884	133,784	132,100	0	0	90.00
91.00	09100	EMERGENCY	6,966,700	1,301,005	5,665,695	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	990,557	191,485	799,072	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	30,257,151	6,544,500	23,712,651	0	0	200.00
201.00		Less Observation Beds	990,557	191,485	799,072	0	0	201.00
202.00		Total (line 200 minus line 201)	29,266,594	6,353,015	22,913,579	0	0	202.00

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

Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet C Part II | Date/Time Prepared: 10/29/2021 5:12 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	331,699	160,598	2.065399	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	787,870	2,732	288.385798	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,537,968	39,059,699	0.141782	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	687,481	39,668	17.330871	59.00
60.00	06000	LABORATORY	5,993,477	31,274,181	0.191643	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	165,242	263,308	0.627562	62.00
65.00	06500	RESPIRATORY THERAPY	1,877,119	5,865,404	0.320032	65.00
66.00	06600	PHYSICAL THERAPY	990,864	432,178	2.292722	66.00
67.00	06700	OCCUPATIONAL THERAPY	406,342	314,290	1.292889	67.00
68.00	06800	SPEECH PATHOLOGY	146,160	44,599	3.277204	68.00
69.00	06900	ELECTROCARDIOLOGY	301,082	1,752,492	0.171802	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	66,312	540,900	0.122596	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,190	42,778	0.799243	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,443,274	17,811,533	0.193317	73.00
74.00	07400	RENAL DIALYSIS	267,274	90,483	2.953859	74.00
76.00	03950	MISC ANCILLARY	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	76.02
76.03	03952	WOUND CARE	997,656	67,272	14.830182	76.03
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	265,884	299,932	0.886481	90.00
91.00	09100	EMERGENCY	6,966,700	31,956,828	0.218003	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	990,557	1,713,460	0.578103	92.00
200.00		Subtotal (sum of lines 50 thru 199)	30,257,151	131,732,335		200.00
201.00		Less Observation Beds	990,557	0		201.00
202.00		Total (line 200 minus line 201)	29,266,594	131,732,335		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet D Part I Date/Time Prepared: 10/29/2021 5:12 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,946,576	0	3,946,576	10,264	384.51	30.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	3,946,576		3,946,576	10,264		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	1,355	521,011	30.00
33.00	BURN INTENSIVE CARE UNIT	0	0	33.00
40.00	SUBPROVIDER - IPF	0	0	40.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	1,355	521,011	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0047	Period: From 06/01/2020 To 05/31/2021	Worksheet D Part II Date/Time Prepared: 10/29/2021 5:12 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	22,441	160,598	0.139734	15,153	2,117	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	3,939	2,732	1.441801	378	545	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,338,685	39,059,699	0.034273	873,017	29,921	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	151,814	39,668	3.827115	0	0	59.00
60.00	06000	LABORATORY	1,185,570	31,274,181	0.037909	1,365,528	51,766	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	55,468	263,308	0.210658	9,181	1,934	62.00
65.00	06500	RESPIRATORY THERAPY	410,356	5,865,404	0.069962	1,230,657	86,099	65.00
66.00	06600	PHYSICAL THERAPY	465,146	432,178	1.076283	98,092	105,575	66.00
67.00	06700	OCCUPATIONAL THERAPY	179,288	314,290	0.570454	71,763	40,937	67.00
68.00	06800	SPEECH PATHOLOGY	68,477	44,599	1.535393	9,852	15,127	68.00
69.00	06900	ELECTROCARDIOLOGY	78,305	1,752,492	0.044682	51,374	2,295	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,082	540,900	0.013093	125,201	1,639	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	459	42,778	0.010730	10,242	110	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	293,803	17,811,533	0.016495	2,300,789	37,952	73.00
74.00	07400	RENAL DIALYSIS	125,176	90,483	1.383420	20,251	28,016	74.00
76.00	03950	MISC ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.02
76.03	03952	WOUND CARE	532,217	67,272	7.911419	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	133,784	299,932	0.446048	0	0	90.00
91.00	09100	EMERGENCY	1,301,005	31,956,828	0.040711	438,387	17,847	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	191,485	1,713,460	0.111753	88,183	9,855	92.00
200.00		Total (lines 50 through 199)	6,544,500	131,732,335		6,708,048	431,735	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet D Part III Date/Time Prepared: 10/29/2021 5:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	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
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
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	10,264	0.00	1,355	30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	0	0.00	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	10,264		1,355	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
33.00	03300	BURN INTENSIVE CARE UNIT	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
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: 15-0047

Period: From 06/01/2020 To 05/31/2021

Worksheet D Part IV

Date/Time Prepared: 10/29/2021 5:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet D Part IV Date/Time Prepared: 10/29/2021 5:12 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	160,598	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,732	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	39,059,699	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	39,668	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	31,274,181	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	263,308	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,865,404	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	432,178	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	314,290	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	44,599	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,752,492	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	540,900	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	42,778	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	17,811,533	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	90,483	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	67,272	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	299,932	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	31,956,828	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,713,460	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	131,732,335		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet D Part IV | Date/Time Prepared: 10/29/2021 5:12 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	15,153	0	27,863	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	378	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	873,017	0	2,832,332	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,365,528	0	793,928	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	9,181	0	7,979	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,230,657	0	80,562	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	98,092	0	2,253	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	71,763	0	1,116	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	9,852	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	51,374	0	161,589	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	125,201	0	6,462	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	10,242	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,300,789	0	387,820	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	20,251	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	43,536	0	90.00
91.00	09100	EMERGENCY	0.000000	438,387	0	1,703,857	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	88,183	0	139,150	0	92.00
200.00		Total (lines 50 through 199)		6,708,048	0	6,188,447	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet D Part V Date/Time Prepared: 10/29/2021 5:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2.065399	27,863	0	0	57,548	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	288.385798	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141782	2,832,332	0	0	401,574	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	17.330871	0	0	0	0	59.00
60.00	06000	LABORATORY	0.191643	793,928	9,000	0	152,151	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.627562	7,979	0	0	5,007	62.00
65.00	06500	RESPIRATORY THERAPY	0.320032	80,562	0	0	25,782	65.00
66.00	06600	PHYSICAL THERAPY	2.292722	2,253	0	0	5,166	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.292889	1,116	0	0	1,443	67.00
68.00	06800	SPEECH PATHOLOGY	3.277204	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171802	161,589	0	0	27,761	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.122596	6,462	0	0	792	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.799243	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.193317	387,820	0	8,150	74,972	73.00
74.00	07400	RENAL DIALYSIS	2.953859	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	14.830182	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.886481	43,536	0	183	38,594	90.00
91.00	09100	EMERGENCY	0.218003	1,703,857	0	0	371,446	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.578103	139,150	0	0	80,443	92.00
200.00		Subtotal (see instructions)		6,188,447	9,000	8,333	1,242,679	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		6,188,447	9,000	8,333	1,242,679	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet D Part V | Date/Time Prepared: 10/29/2021 5:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	1,725	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	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	1,576	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	76.00
76.01	03951	SLEEP LAB	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.02
76.03	03952	WOUND CARE	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	162	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	1,725	1,738	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	1,725	1,738	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet D Part I Date/Time Prepared: 10/29/2021 5:12 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,946,576	0	3,946,576	10,264	384.51	30.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	3,946,576		3,946,576	10,264		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	1,070	411,426	30.00
33.00	BURN INTENSIVE CARE UNIT	0	0	33.00
40.00	SUBPROVIDER - IPF	0	0	40.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	1,070	411,426	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0047	Period: From 06/01/2020 To 05/31/2021	Worksheet D Part II Date/Time Prepared: 10/29/2021 5:12 pm
	Title XIX	Hospital	PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,441	160,598	0.139734	7,957	1,112	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	3,939	2,732	1.441801	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,338,685	39,059,699	0.034273	664,485	22,774	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	151,814	39,668	3.827115	0	0	59.00
60.00	06000	LABORATORY	1,185,570	31,274,181	0.037909	1,005,878	38,132	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	55,468	263,308	0.210658	29,102	6,131	62.00
65.00	06500	RESPIRATORY THERAPY	410,356	5,865,404	0.069962	737,127	51,571	65.00
66.00	06600	PHYSICAL THERAPY	465,146	432,178	1.076283	42,792	46,056	66.00
67.00	06700	OCCUPATIONAL THERAPY	179,288	314,290	0.570454	29,797	16,998	67.00
68.00	06800	SPEECH PATHOLOGY	68,477	44,599	1.535393	2,885	4,430	68.00
69.00	06900	ELECTROCARDIOLOGY	78,305	1,752,492	0.044682	41,725	1,864	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,082	540,900	0.013093	65,998	864	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	459	42,778	0.010730	4,767	51	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	293,803	17,811,533	0.016495	1,747,959	28,833	73.00
74.00	07400	RENAL DIALYSIS	125,176	90,483	1.383420	38,086	52,689	74.00
76.00	03950	MISC ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.02
76.03	03952	WOUND CARE	532,217	67,272	7.911419	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	133,784	299,932	0.446048	2,193	978	90.00
91.00	09100	EMERGENCY	1,301,005	31,956,828	0.040711	511,101	20,807	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	191,485	1,713,460	0.111753	54,776	6,121	92.00
200.00		Total (lines 50 through 199)	6,544,500	131,732,335		4,986,628	299,411	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet D Part III Date/Time Prepared: 10/29/2021 5:12 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	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
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
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	10,264	0.00	1,070	30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	0	0.00	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	10,264		1,070	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
33.00	03300	BURN INTENSIVE CARE UNIT	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
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: 15-0047

Period: From 06/01/2020 To 05/31/2021

Worksheet D Part IV

Date/Time Prepared: 10/29/2021 5:12 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet D Part IV | Date/Time Prepared: 10/29/2021 5:12 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	160,598	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,732	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	39,059,699	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	39,668	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	31,274,181	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	263,308	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,865,404	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	432,178	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	314,290	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	44,599	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,752,492	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	540,900	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	42,778	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	17,811,533	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	90,483	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	67,272	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	299,932	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	31,956,828	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,713,460	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	131,732,335		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet D Part IV | Date/Time Prepared: 10/29/2021 5:12 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	7,957	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	664,485	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,005,878	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	29,102	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	737,127	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	42,792	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	29,797	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,885	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	41,725	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	65,998	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,767	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,747,959	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	38,086	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	2,193	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	511,101	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	54,776	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,986,628	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet D Part V Date/Time Prepared: 10/29/2021 5:12 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2.065399	0	0	2,115	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	288.385798	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141782	0	0	2,933,952	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	17.330871	0	0	0	0	59.00
60.00	06000	LABORATORY	0.191643	0	0	1,370,313	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.627562	0	0	12,343	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.320032	0	0	131,433	0	65.00
66.00	06600	PHYSICAL THERAPY	2.292722	0	0	1,714	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.292889	0	0	2,303	0	67.00
68.00	06800	SPEECH PATHOLOGY	3.277204	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171802	0	0	96,396	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.122596	0	0	2,439	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.799243	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.193317	0	0	445,935	0	73.00
74.00	07400	RENAL DIALYSIS	2.953859	0	0	3,574	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	14.830182	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.886481	0	0	6,075	0	90.00
91.00	09100	EMERGENCY	0.218003	0	0	2,469,239	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.578103	0	0	102,652	0	92.00
200.00		Subtotal (see instructions)		0	0	7,580,483	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	7,580,483	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet D Part V Date/Time Prepared: 10/29/2021 5:12 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	4,368	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	415,982	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	262,611	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	7,746	62.00
65.00	06500	RESPIRATORY THERAPY	0	42,063	65.00
66.00	06600	PHYSICAL THERAPY	0	3,930	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,978	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,561	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	299	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	86,207	73.00
74.00	07400	RENAL DIALYSIS	0	10,557	74.00
76.00	03950	MISC ANCILLARY	0	0	76.00
76.01	03951	SLEEP LAB	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.02
76.03	03952	WOUND CARE	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	5,385	90.00
91.00	09100	EMERGENCY	0	538,302	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	59,343	92.00
200.00		Subtotal (see instructions)	0	1,456,332	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	1,456,332	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet D-1 | Date/Time Prepared: 10/29/2021 5:12 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)	10,264	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,264	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)	9,766	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,355	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)	20,415,792	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)	20,415,792	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)	20,415,792	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)	1,989.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,695,190	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)	2,695,190	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet D-1 | Date/Time Prepared: 10/29/2021 5:12 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	1,958,869	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,654,059	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)	521,011	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	431,735	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	952,746	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,701,313	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)	498	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,989.07	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	990,557	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet D-1 | Date/Time Prepared: 10/29/2021 5:12 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,946,576	20,415,792	0.193310	990,557	191,485	90.00
91.00	Nursing School cost	0	20,415,792	0.000000	990,557	0	91.00
92.00	Allied health cost	0	20,415,792	0.000000	990,557	0	92.00
93.00	All other Medical Education	0	20,415,792	0.000000	990,557	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047	Period: From 06/01/2020 To 05/31/2021	Worksheet D-1 Date/Time Prepared: 10/29/2021 5:12 pm
	Title XIX	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10,264	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,264	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)	9,766	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,070	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)	20,415,792	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)	20,415,792	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)	20,415,792	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)	1,989.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,128,305	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)	2,128,305	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet D-1 | Date/Time Prepared: 10/29/2021 5:12 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	1,318,183	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,446,488	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)	411,426	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	299,411	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	710,837	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,735,651	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)	498	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,989.07	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	990,557	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047	Period: From 06/01/2020 To 05/31/2021	Worksheet D-1 Date/Time Prepared: 10/29/2021 5:12 pm
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	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,946,576	20,415,792	0.193310	990,557	191,485	90.00
91.00	Nursing School cost	0	20,415,792	0.000000	990,557	0	91.00
92.00	Allied health cost	0	20,415,792	0.000000	990,557	0	92.00
93.00	All other Medical Education	0	20,415,792	0.000000	990,557	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet D-3 | Date/Time Prepared: 10/29/2021 5:12 pm

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		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		4,803,439		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2.065399	15,153	31,297	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	288.385798	378	109,010	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141782	873,017	123,778	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	17.330871	0	0	59.00
60.00	06000	LABORATORY	0.191643	1,365,528	261,694	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.627562	9,181	5,762	62.00
65.00	06500	RESPIRATORY THERAPY	0.320032	1,230,657	393,850	65.00
66.00	06600	PHYSICAL THERAPY	2.292722	98,092	224,898	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.292889	71,763	92,782	67.00
68.00	06800	SPEECH PATHOLOGY	3.277204	9,852	32,287	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171802	51,374	8,826	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.122596	125,201	15,349	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.799243	10,242	8,186	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.193317	2,300,789	444,782	73.00
74.00	07400	RENAL DIALYSIS	2.953859	20,251	59,819	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
76.03	03952	WOUND CARE	14.830182	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.886481	0	0	90.00
91.00	09100	EMERGENCY	0.218003	438,387	95,570	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.578103	88,183	50,979	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,708,048	1,958,869	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		6,708,048		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0047	Period: From 06/01/2020 To 05/31/2021	Worksheet D-3 Date/Time Prepared: 10/29/2021 5:12 pm
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		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		3,386,378		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2.065399	7,957	16,434	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	288.385798	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141782	664,485	94,212	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	17.330871	0	0	59.00
60.00	06000	LABORATORY	0.191643	1,005,878	192,769	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.627562	29,102	18,263	62.00
65.00	06500	RESPIRATORY THERAPY	0.320032	737,127	235,904	65.00
66.00	06600	PHYSICAL THERAPY	2.292722	42,792	98,110	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.292889	29,797	38,524	67.00
68.00	06800	SPEECH PATHOLOGY	3.277204	2,885	9,455	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171802	41,725	7,168	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.122596	65,998	8,091	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.799243	4,767	3,810	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.193317	1,747,959	337,910	73.00
74.00	07400	RENAL DIALYSIS	2.953859	38,086	112,501	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
76.03	03952	WOUND CARE	14.830182	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.886481	2,193	1,944	90.00
91.00	09100	EMERGENCY	0.218003	511,101	111,422	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.578103	54,776	31,666	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,986,628	1,318,183	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)		4,986,628		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Period: From 06/01/2020 To 05/31/2021	Worksheet E Part A Date/Time Prepared: 10/29/2021 5:12 pm
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		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)	512,200	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,364,389	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)	7,253	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	168,068	2.04
3.00	Managed Care Simulated Payments	1,603,598	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	59.60	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	8.95	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.	1.89	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).	-6.37	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)	0.69	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.83	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)	0.69	12.00
13.00	Total allowable FTE count for the prior year.	0.42	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.	0.50	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.54	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	0.54	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.009060	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.004981	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.004981	21.00
22.00	IME payment adjustment (see instructions)	5,102	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	4,360	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).	4.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.14	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)	0.14	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.002349	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000628	27.00
28.00	IME add-on adjustment amount (see instructions)	1,178	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	1,007	28.01
29.00	Total IME payment (sum of lines 22 and 28)	6,280	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	5,367	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	13.86	30.00
31.00	Percentage of Medicaid patient days (see instructions)	54.82	31.00
32.00	Sum of lines 30 and 31	68.68	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	56,298	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Period: From 06/01/2020 To 05/31/2021	Worksheet E Part A Date/Time Prepared: 10/29/2021 5:12 pm
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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,305,861	762,335	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	435,287	507,527	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	942,814		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	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 excluding MS-DRGs 652, 682, 683, 684 an 685. (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	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)	3,057,302		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)	3,062,669	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	186,453	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).	13,731	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	85,098	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	3,347,951	59.00
60.00	Primary payer payments	5,844	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	3,342,107	61.00
62.00	Deductibles billed to program beneficiaries	214,276	62.00
63.00	Coinsurance billed to program beneficiaries	16,211	63.00
64.00	Allowable bad debts (see instructions)	137,691	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	89,499	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	52,699	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	3,201,119	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)	-1,416	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet E Part A | Date/Time Prepared: 10/29/2021 5:12 pm

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,199,703	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		2,675,067	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)		524,636	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		703,978	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

CALCULATION OF REIMBURSEMENT SETTLEMENT

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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,463	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	1,242,679	2.00
3.00	OPPS payments	521,507	3.00
4.00	Outlier payment (see instructions)	2,266	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)	3,463	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	17,333	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)	17,333	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)	17,333	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	13,870	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)	3,463	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)	523,773	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	811	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	85,983	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)	440,442	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	3,680	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)	444,122	30.00
31.00	Primary payer payments	418	31.00
32.00	Subtotal (line 30 minus line 31)	443,704	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)	80,510	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	52,332	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	29,212	36.00
37.00	Subtotal (see instructions)	496,036	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-137	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)	496,173	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	569,414	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)	-73,241	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: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet E-1 Part I Date/Time Prepared: 10/29/2021 5:12 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,675,067		569,414	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)		2,675,067		569,414	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		524,636		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		73,241	6.02
7.00	Total Medicare program liability (see instructions)		3,199,703		496,173	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: 15-0047	Period: From 06/01/2020 To 05/31/2021	Worksheet E-1 Part II Date/Time Prepared: 10/29/2021 5:12 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		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: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet E-3 Part VII Date/Time Prepared: 10/29/2021 5:12 pm

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		1,456,332	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	1,456,332	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	1,456,332	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	3,386,378		8.00
9.00	Ancillary service charges	4,986,628	7,580,483	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	8,373,006	7,580,483	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	8,373,006	7,580,483	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	8,373,006	6,124,151	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	1,456,332	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	1,456,332	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	1,456,332	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	1,456,332	36.00
37.00	ELIMINATE SETTLEMENT	0	-1,456,332	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet E-4 | Date/Time Prepared: 10/29/2021 5:12 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.	7.63	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))	-6.94	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	0.69	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)	0.83	6.00
7.00	Enter the lesser of line 5 or line 6	0.69	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.	0.83	0.00	0.83	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.	0.69	0.00	0.69	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	0.69	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.42	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.50	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.54	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	0.54	0.00		17.00
18.00	Per resident amount	105,676.15	100,066.03		18.00
19.00	Approved amount for resident costs	57,065	0	57,065	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)	5.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)	0.14	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)	0.14	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)	105,092.06	23.00
24.00	Multiply line 22 time line 23	14,713	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)	71,778	25.00

		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total	
		1.00	2.00	2.01	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)	1,355	326	731		26.00
27.00	Total Inpatient Days (see instructions)	9,766	9,766	9,766		27.00
28.00	Ratio of inpatient days to total inpatient days	0.138747	0.033381	0.074852		28.00
29.00	Program direct GME amount	9,959	2,396	5,373	17,728	29.00
29.01	Percent reduction for MA DGME		4.07	4.07		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		98	219	317	30.00
31.00	Net Program direct GME amount				17,411	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0047	Period: From 06/01/2020 To 05/31/2021	Worksheet E-4 Date/Time Prepared: 10/29/2021 5:12 pm
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL 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)	90,483	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)	4,654,059	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)	5,844	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	4,648,215	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	1,246,142	42.00
43.00	Primary payer payments (see instructions)	418	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	1,245,724	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	5,893,939	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.788643	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.211357	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	17,411	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	13,731	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	3,680	50.00

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

Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet G | Date/Time Prepared: 10/29/2021 5:12 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	-297,631	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	19,870,980	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,228,083	0	0	0	6.00
7.00	Inventory	1,512,173	0	0	0	7.00
8.00	Prepaid expenses	492,452	0	0	0	8.00
9.00	Other current assets	851,300	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)	13,201,191	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,010,000	0	0	0	12.00
13.00	Land improvements	412,126	0	0	0	13.00
14.00	Accumulated depreciation	-316,600	0	0	0	14.00
15.00	Buildings	28,390,448	0	0	0	15.00
16.00	Accumulated depreciation	-32,035,562	0	0	0	16.00
17.00	Leasehold improvements	23,512,367	0	0	0	17.00
18.00	Accumulated depreciation	-11,567,911	0	0	0	18.00
19.00	Fixed equipment	1,508,715	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	17,351,982	0	0	0	23.00
24.00	Accumulated depreciation	-14,252,761	0	0	0	24.00
25.00	Minor equipment depreciable	7,671,064	0	0	0	25.00
26.00	Accumulated depreciation	-7,767,524	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)	13,916,344	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	13,739,386	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	13,739,386	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	40,856,921	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	601,747	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,377,128	0	0	0	38.00
39.00	Payroll taxes payable	146,605	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	63,219,901	0	0	0	43.00
44.00	Other current liabilities	7,115,057	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	72,460,438	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	72,460,438	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-31,603,517				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)	-31,603,517	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	40,856,921	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet G-1 | Date/Time Prepared: 10/29/2021 5:12 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		-10,505,038		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-21,098,479				2.00
3.00	Total (sum of line 1 and line 2)		-31,603,517		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)		-31,603,517		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)		-31,603,517		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: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet G-2 Parts I & II | Date/Time Prepared: 10/29/2021 5:12 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	28,998,295		28,998,295	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	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)	28,998,295		28,998,295	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	28,998,295		28,998,295	17.00
18.00	Ancillary services	33,388,885	64,373,229	97,762,114	18.00
19.00	Outpatient services	4,754,776	29,215,444	33,970,220	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	CONTRACTED HOSPICE	96,755	0	96,755	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	67,238,711	93,588,673	160,827,384	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		60,785,209		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)		60,785,209		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2020 To 05/31/2021 | Worksheet G-3 | Date/Time Prepared: 10/29/2021 5:12 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	160,827,384	1.00
2.00	Less contractual allowances and discounts on patients' accounts	133,522,058	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,305,326	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	60,785,209	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-33,479,883	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISC GAIN/LOSS	-30,833	24.00
24.50	COVID-19 PHE Funding	12,412,237	24.50
25.00	Total other income (sum of lines 6-24)	12,381,404	25.00
26.00	Total (line 5 plus line 25)	-21,098,479	26.00
27.00	OTHER	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)	-21,098,479	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0047	Period: From 06/01/2020 To 05/31/2021	Worksheet L Parts I-III Date/Time Prepared: 10/29/2021 5:12 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	140,307	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	45,136	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)	26.81	3.00
4.00	Number of interns & residents (see instructions)	0.68	4.00
5.00	Indirect medical education percentage (see instructions)	0.72	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)	1,010	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	186,453	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