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: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/18/2021 4:43 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/18/2021 Time: 4:43 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 ASCENSION ST. VINCENT CLAY (15-1309) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[X] 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) CHRIS HONS
Officer or Administrator of Provider(s)

VP OF FINANCE
Title

11/18/2021 04:42:58 PM
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	81,379	50,410	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	252,947	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	334,326	50,410	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: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/18/2021 4:43 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1206 EAST NATIONAL AVENUE	PO Box:			1.00
2.00	City: BRAZIL	State: IN	Zip Code: 47834	County: CLAY	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	ASCENSION ST. VINCENT CLAY	151309	45460	1	08/08/2001	N	O	O	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	ASCENSION ST. VINCENT CLAY SWING	15Z309	45460		08/08/2001	N	O	N	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)	07/01/2020	06/30/2021	20.00
21.00	Type of Control (see instructions)	1		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I | Date/Time Prepared: 11/18/2021 4:43 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.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				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: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/18/2021 4:43 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2021 4:43 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2021 4:43 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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		Y	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2021 4:43 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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	114,685	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	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	15H046	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/18/2021 4:43 pm

		1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS		Contractor's Number: 08001	141.00
142.00	Street: 250 WEST 96TH STREET SUITE 215	PO Box:			142.00
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46260	143.00

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part II | Date/Time Prepared: 11/18/2021 4:43 pm

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

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

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for 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.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/08/2021	Y	10/08/2021	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: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part II Date/Time Prepared: 11/18/2021 4:43 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.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			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.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL		HILL		41.00
42.00	Enter the employer/company name of the cost report preparer.	ASCENSION				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3519		JILL.HILL1@ASCENSION.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/18/2021 4:43 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.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I Date/Time Prepared: 11/18/2021 4:43 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	25	9,125	5,736.00	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)		25	9,125	5,736.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	5,736.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				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: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I Date/Time Prepared: 11/18/2021 4:43 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)	130	0	239			1.00
2.00	HMO and other (see instructions)	12	33				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	342	0	381			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)	472	0	620			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)	472	0	620	0.00	51.56	14.00
15.00	CAH visits	8,518	544	31,340			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	51.56	27.00
28.00	Observation Bed Days		0	336			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			3			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: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I | Date/Time Prepared: 11/18/2021 4:43 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	26	0	59	1.00
2.00	HMO and other (see instructions)			5	12		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	26	0	59	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-10 | Date/Time Prepared: 11/18/2021 4:43 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)	0.306153	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,393,690	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	15,163,784	6.00
7.00	Medicaid cost (line 1 times line 6)	4,642,438	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)	3,248,748	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)	3,248,748	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)	1,053,929	345,165	1,399,094	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	322,664	345,165	667,829	21.00
22.00	Payments received from patients for amounts previously written off as charity care	93,660	12,540	106,200	22.00
23.00	Cost of charity care (line 21 minus line 22)	229,004	332,625	561,629	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)	2,771,869	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	209,030	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	321,585	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,450,284	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	862,717	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,424,346	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,673,094	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A | Date/Time Prepared: 11/18/2021 4:43 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		405,627	405,627	0	405,627	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		529,823	529,823	0	529,823	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	135,606	1,026,366	1,161,972	0	1,161,972	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	407,391	5,805,518	6,212,909	-43,220	6,169,689	5.00
7.00	00700	OPERATION OF PLANT	0	963,443	963,443	10,408	973,851	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	51,103	51,103	0	51,103	8.00
9.00	00900	HOUSEKEEPING	0	409,919	409,919	11,202	421,121	9.00
10.00	01000	DIETARY	0	388,220	388,220	-337,155	51,065	10.00
11.00	01100	CAFETERIA	0	0	0	343,810	343,810	11.00
13.00	01300	NURSING ADMINISTRATION	155,279	7,777	163,056	1,339	164,395	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,668	13,952	22,620	7,747	30,367	14.00
15.00	01500	PHARMACY	233,665	307,341	541,006	0	541,006	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	756,969	46,475	803,444	-274	803,170	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	318,305	253,206	571,511	-115,539	455,972	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	650,830	214,915	865,745	0	865,745	54.00
60.00	06000	LABORATORY	35,517	1,588,236	1,623,753	0	1,623,753	60.00
65.00	06500	RESPIRATORY THERAPY	129,417	29,030	158,447	337	158,784	65.00
66.00	06600	PHYSICAL THERAPY	0	821,952	821,952	-194,028	627,924	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	189,691	189,691	67.00
68.00	06800	SPEECH PATHOLOGY	0	72,672	72,672	0	72,672	68.00
69.00	06900	ELECTROCARDIOLOGY	75,478	11,815	87,293	0	87,293	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	666	666	128,782	129,448	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	123,394	123,394	0	123,394	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	744,867	1,371,536	2,116,403	-3,100	2,113,303	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)	3,651,992	14,442,986	18,094,978	0	18,094,978	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	27,334	27,334	0	27,334	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MISSION SERVICES	0	30	30	0	30	193.01
200.00		TOTAL (SUM OF LINES 118 through 199)	3,651,992	14,470,350	18,122,342	0	18,122,342	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A | Date/Time Prepared: 11/18/2021 4:43 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	0	405,627		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	529,823		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,448	1,168,420		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-694,306	5,475,383		5.00
7.00	00700	OPERATION OF PLANT	0	973,851		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	51,103		8.00
9.00	00900	HOUSEKEEPING	0	421,121		9.00
10.00	01000	DIETARY	0	51,065		10.00
11.00	01100	CAFETERIA	-28,573	315,237		11.00
13.00	01300	NURSING ADMINISTRATION	0	164,395		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	30,367		14.00
15.00	01500	PHARMACY	-841	540,165		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	803,170		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-12,150	443,822		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-8,546	857,199		54.00
60.00	06000	LABORATORY	0	1,623,753		60.00
65.00	06500	RESPIRATORY THERAPY	0	158,784		65.00
66.00	06600	PHYSICAL THERAPY	0	627,924		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	189,691		67.00
68.00	06800	SPEECH PATHOLOGY	0	72,672		68.00
69.00	06900	ELECTROCARDIOLOGY	0	87,293		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	129,448		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	123,394		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	2,113,303		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)	-737,968	17,357,010		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	27,334		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	MISSION SERVICES	0	30		193.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-737,968	17,384,374		200.00

RECLASSIFICATIONS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-6 | Date/Time Prepared: 11/18/2021 4:43 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PANDEMIC WORKERS COMP					
1.00	EMERGENCY	91.00	0	2,485		1.00
	TOTALS		0	2,485		
	B - CAFETERIA					
1.00	CAFETERIA	11.00		343,810		1.00
			0	343,810		
	C - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		128,782		1.00
2.00						2.00
3.00						3.00
4.00						4.00
			0	128,782		
	D - OT RECLASS					
1.00	OCCUPATIONAL THERAPY	67.00	0	189,691		1.00
	TOTALS		0	189,691		
	F - Pandemic Other Expenses					
1.00	CENTRAL SERVICES & SUPPLY	14.00		7,747		1.00
2.00	DIETARY	10.00		6,655		2.00
3.00	HOUSEKEEPING	9.00		11,202		3.00
4.00	OPERATION OF PLANT	7.00		10,408		4.00
			0	36,012		
	G - Pandemic Salaries & Benefits					
1.00	NURSING ADMINISTRATION	13.00	1,140	199		1.00
2.00	ADULTS & PEDIATRICS	30.00	340	59		2.00
3.00	OPERATING ROOM	50.00	2,494	435		3.00
4.00	RESPIRATORY THERAPY	65.00	287	50		4.00
5.00	EMERGENCY	91.00	1,877	327		5.00
			6,138	1,070		
500.00	Grand Total: Increases		6,138	701,850		500.00

RECLASSIFICATIONS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-6 | Date/Time Prepared: 11/18/2021 4:43 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PANDEMIC WORKERS COMP						
1.00	EMERGENCY	91.00	2,485	0	0		1.00
	TOTALS		2,485	0			
	B - CAFETERIA						
1.00	DIETARY	10.00		343,810			1.00
			0	343,810			
	C - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00		673			1.00
2.00	OPERATING ROOM	50.00		118,468			2.00
3.00	PHYSICAL THERAPY	66.00		4,337			3.00
4.00	EMERGENCY	91.00		5,304			4.00
			0	128,782			
	D - OT RECLASS						
1.00	PHYSICAL THERAPY	66.00	0	189,691	0		1.00
	TOTALS		0	189,691			
	F - Pandemic Other Expenses						
1.00	ADMINISTRATIVE & GENERAL	5.00		36,012			1.00
2.00							2.00
3.00							3.00
4.00							4.00
			0	36,012			
	G - Pandemic Salaries & Benefits						
1.00	ADMINISTRATIVE & GENERAL	5.00	6,138	1,070			1.00
2.00							2.00
3.00							3.00
4.00							4.00
5.00							5.00
			6,138	1,070			
500.00	Grand Total: Decreases		8,623	699,365			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part I Date/Time Prepared: 11/18/2021 4:43 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,500	0	0	0	0	1.00
2.00	Land Improvements	284,755	173,476	0	173,476	0	2.00
3.00	Buildings and Fixtures	10,940,946	0	0	0	226,487	3.00
4.00	Building Improvements	995,040	0	0	0	0	4.00
5.00	Fixed Equipment	3,117,832	13,504	0	13,504	0	5.00
6.00	Movable Equipment	7,752,368	218,680	0	218,680	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	23,093,441	405,660	0	405,660	226,487	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	23,093,441	405,660	0	405,660	226,487	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,500	0	1.00
2.00	Land Improvements	458,231	0	2.00
3.00	Buildings and Fixtures	10,714,459	0	3.00
4.00	Building Improvements	995,040	0	4.00
5.00	Fixed Equipment	3,131,336	0	5.00
6.00	Movable Equipment	7,971,048	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	23,272,614	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	23,272,614	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part II Date/Time Prepared: 11/18/2021 4:43 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	405,627	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	496,405	33,418	0	0	0	2.00
3.00	Total (sum of lines 1-2)	902,032	33,418	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	405,627	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	529,823	2.00
3.00	Total (sum of lines 1-2)	0	935,450	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part III Date/Time Prepared: 11/18/2021 4:43 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	12,170,230	0	12,170,230	0.522942	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,102,384	0	11,102,384	0.477058	0	2.00
3.00	Total (sum of lines 1-2)	23,272,614	0	23,272,614	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	405,627	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	496,405	33,418	2.00
3.00	Total (sum of lines 1-2)	0	0	0	902,032	33,418	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	405,627	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	529,823	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	935,450	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8 | Date/Time Prepared: 11/18/2021 4:43 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-235,598	CAP REL COSTS-BLDG & FIXT	1.00	11	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)	B	-8,234	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-20,696			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	1,909,617			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-28,573	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-841	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	Admin Revenue	B	-1,208	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8 | Date/Time Prepared: 11/18/2021 4:43 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.03	LOBBYING	A	-474	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	DONATIONS	A	-3,672	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.06	PROVIDER TAX	A	-1,005,079	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.08	Physician Fund Expense	A	-1,343,210	ADMINISTRATIVE & GENERAL	5.00	0	33.08
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-737,968				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: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-1 | Date/Time Prepared: 11/18/2021 4:43 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	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	290,981	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST - Cap	5,157	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST - A&G	96	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	4,623,491	3,016,556	3.01
3.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	1,416	1,416	3.02
3.03	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACKS	45,784	45,784	3.03
3.04	69.00	ELECTROCARDIOLOGY	SVH CHARGEBACKS	10,096	10,096	3.04
3.05	91.00	EMERGENCY	SVH CHARGEBACKS	-500	-500	3.05
3.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	672,696	666,248	3.07
3.08	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	235,598	0	3.08
3.09	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	2,981	238,579	3.09
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,887,796	3,978,179	5.00

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

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

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

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

6.00	G	ASCENSION SVH	100.00	ASCENSION SVH	100.00	6.00
7.00	G	Ascension	100.00	Ascension	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	Home Office				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: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-1 | Date/Time Prepared: 11/18/2021 4:43 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	290,981	0		1.00
2.00	5,157	0		2.00
3.00	96	0		3.00
3.01	1,606,935	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
3.07	6,448	0		3.07
3.08	235,598	11		3.08
3.09	-235,598	0		3.09
4.00	0	0		4.00
5.00	1,909,617			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	Administration		6.00
7.00	Administration		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-2 | Date/Time Prepared: 11/18/2021 4:43 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	50.00	OPERATING ROOM	12,150	12,150	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	8,546	8,546	0	0	0	2.00
3.00	91.00	EMERGENCY	1,294,177	0	1,294,177	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,314,873	20,696	1,294,177		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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			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	50.00	OPERATING ROOM	0	0	0	12,150		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	8,546		2.00
3.00	91.00	EMERGENCY	0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	20,696		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/18/2021 4:43 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					304	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					5	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					9.57	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	2,023.00	2,037.00	6,032.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	98.87	85.97	55.88	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	42.99	42.99	27.94			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					200,014	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					175,121	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					337,068	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					712,203	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					712,203	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					712,203	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					13,069	24.00
25.00	Assistants (line 4 times column 3, line 11)					140	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					13,209	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,957	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					16,166	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					16,166	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/18/2021 4:43 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	85.97	55.88	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	712,203		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	16,166		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	728,369		63.00
64.00	Total cost of outside supplier services (from your records)	629,696		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	13,209		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,957		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	16,166		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,957		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	2,957		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/18/2021 4:43 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		250	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		9.57	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2,421.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	81.50	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.75	40.75	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	197,312	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	197,312	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	197,312	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	197,312	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	10,188	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	10,188	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	2,393	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	12,581	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	12,581	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/18/2021 4:43 pm

		Occupational Therapy	Cost
		1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	81.50	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	197,312	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	12,581	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	209,893	63.00
64.00	Total cost of outside supplier services (from your records)	173,742	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	10,188	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,393	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	12,581	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,393	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	2,393	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/18/2021 4:43 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					183	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					9.57	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,179.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	78.34	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.17	39.17	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					92,363	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					92,363	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					92,363	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					92,363	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					7,168	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					7,168	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,751	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					8,919	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					8,919	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/18/2021 4:43 pm

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	78.34	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	92,363		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	8,919		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	101,282		63.00
64.00	Total cost of outside supplier services (from your records)	72,672		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	7,168		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,751		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	8,919		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,751		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	1,751		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I Date/Time Prepared: 11/18/2021 4:43 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	405,627	405,627				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	529,823		529,823			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,168,420	0	0	1,168,420		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,475,383	151,465	197,841	133,422	5,958,111	5.00
7.00	00700	OPERATION OF PLANT	973,851	83,242	108,730	0	1,165,823	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	51,103	8,700	11,364	0	71,167	8.00
9.00	00900	HOUSEKEEPING	421,121	4,825	6,302	0	432,248	9.00
10.00	01000	DIETARY	51,065	10,717	13,998	0	75,780	10.00
11.00	01100	CAFETERIA	315,237	6,079	7,940	0	329,256	11.00
13.00	01300	NURSING ADMINISTRATION	164,395	9,497	12,405	52,012	238,309	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	30,367	0	0	2,882	33,249	14.00
15.00	01500	PHARMACY	540,165	4,761	6,219	77,697	628,842	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	42,209	55,132	0	97,341	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	803,170	27,400	35,789	251,815	1,118,174	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	443,822	11,248	14,692	106,670	576,432	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	857,199	7,800	10,189	216,410	1,091,598	54.00
60.00	06000	LABORATORY	1,623,753	6,379	8,332	11,810	1,650,274	60.00
65.00	06500	RESPIRATORY THERAPY	158,784	7,692	10,047	43,128	219,651	65.00
66.00	06600	PHYSICAL THERAPY	627,924	0	0	0	627,924	66.00
67.00	06700	OCCUPATIONAL THERAPY	189,691	0	0	0	189,691	67.00
68.00	06800	SPEECH PATHOLOGY	72,672	0	0	0	72,672	68.00
69.00	06900	ELECTROCARDIOLOGY	87,293	0	0	25,097	112,390	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,448	0	0	0	129,448	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	123,394	0	0	0	123,394	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,113,303	22,570	29,481	247,477	2,412,831	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)	17,357,010	404,584	528,461	1,168,420	17,354,605	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,043	1,362	0	2,405	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	27,334	0	0	0	27,334	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MISSION SERVICES	30	0	0	0	30	193.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,384,374	405,627	529,823	1,168,420	17,384,374	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I Date/Time Prepared: 11/18/2021 4:43 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,958,111					5.00
7.00	00700	OPERATION OF PLANT	607,907	1,773,730				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	37,109	78,717	186,993			8.00
9.00	00900	HOUSEKEEPING	225,391	43,652	581	701,872		9.00
10.00	01000	DIETARY	39,515	96,961	0	0	212,256	10.00
11.00	01100	CAFETERIA	171,687	54,999	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	124,264	85,925	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,337	0	0	0	0	14.00
15.00	01500	PHARMACY	327,903	43,074	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	50,757	381,880	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	583,061	247,898	32,776	177,106	212,256	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	300,575	101,767	23,876	112,582	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	569,203	148,667	33,757	109,394	0	54.00
60.00	06000	LABORATORY	860,519	57,714	0	29,508	0	60.00
65.00	06500	RESPIRATORY THERAPY	114,535	69,595	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	327,425	149,246	8,373	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	98,912	0	2,094	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	37,894	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	58,605	0	7,081	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	67,499	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,343	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,258,147	204,201	67,669	164,062	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)	5,942,588	1,764,296	176,207	592,652	212,256	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,254	9,434	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,253	0	10,786	109,220	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MISSION SERVICES	16	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,958,111	1,773,730	186,993	701,872	212,256	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I Date/Time Prepared: 11/18/2021 4:43 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	555,942					11.00
13.00	01300	NURSING ADMINISTRATION	19,212	467,710				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,782	0	53,368			14.00
15.00	01500	PHARMACY	29,414	0	0	1,029,233		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	529,978	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	139,780	199,919	0	0	16,156	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	60,019	69,494	0	0	61,907	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	128,254	0	0	0	149,738	54.00
60.00	06000	LABORATORY	12,852	3,933	0	0	108,046	60.00
65.00	06500	RESPIRATORY THERAPY	24,644	0	0	0	6,185	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	26,331	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	6,587	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	2,495	68.00
69.00	06900	ELECTROCARDIOLOGY	15,369	2,795	0	0	22,548	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	53,368	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	1,029,233	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	123,616	191,569	0	0	129,985	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)	555,942	467,710	53,368	1,029,233	529,978	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
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MISSION SERVICES	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	555,942	467,710	53,368	1,029,233	529,978	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I Date/Time Prepared: 11/18/2021 4:43 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,727,126	0	2,727,126		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,306,652	0	1,306,652		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,230,611	0	2,230,611		54.00
60.00	06000	LABORATORY	2,722,846	0	2,722,846		60.00
65.00	06500	RESPIRATORY THERAPY	434,610	0	434,610		65.00
66.00	06600	PHYSICAL THERAPY	1,139,299	0	1,139,299		66.00
67.00	06700	OCCUPATIONAL THERAPY	297,284	0	297,284		67.00
68.00	06800	SPEECH PATHOLOGY	113,061	0	113,061		68.00
69.00	06900	ELECTROCARDIOLOGY	218,788	0	218,788		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	250,315	0	250,315		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	187,737	0	187,737		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,029,233	0	1,029,233		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	4,552,080	0	4,552,080		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)	17,209,642	0	17,209,642		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,093	0	13,093		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	161,593	0	161,593		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	MISSION SERVICES	46	0	46		193.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	17,384,374	0	17,384,374		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II Date/Time Prepared: 11/18/2021 4:43 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	545,130	151,465	197,841	894,436	0	5.00
7.00	00700	OPERATION OF PLANT	0	83,242	108,730	191,972	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,700	11,364	20,064	0	8.00
9.00	00900	HOUSEKEEPING	0	4,825	6,302	11,127	0	9.00
10.00	01000	DIETARY	0	10,717	13,998	24,715	0	10.00
11.00	01100	CAFETERIA	0	6,079	7,940	14,019	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,497	12,405	21,902	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	4,761	6,219	10,980	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	42,209	55,132	97,341	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	27,400	35,789	63,189	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	11,248	14,692	25,940	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,800	10,189	17,989	0	54.00
60.00	06000	LABORATORY	0	6,379	8,332	14,711	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,692	10,047	17,739	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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	22,570	29,481	52,051	0	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)	545,130	404,584	528,461	1,478,175	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,043	1,362	2,405	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MISSION SERVICES	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	545,130	405,627	529,823	1,480,580	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II Date/Time Prepared: 11/18/2021 4:43 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	894,436					5.00
7.00	00700	OPERATION OF PLANT	91,259	283,231				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,571	12,570	38,205			8.00
9.00	00900	HOUSEKEEPING	33,836	6,970	119	52,052		9.00
10.00	01000	DIETARY	5,932	15,483	0	0	46,130	10.00
11.00	01100	CAFETERIA	25,774	8,782	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	18,655	13,721	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,603	0	0	0	0	14.00
15.00	01500	PHARMACY	49,225	6,878	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,620	60,979	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	87,530	39,585	6,697	13,135	46,130	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,123	16,250	4,878	8,349	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	85,449	23,739	6,897	8,113	0	54.00
60.00	06000	LABORATORY	129,182	9,216	0	2,188	0	60.00
65.00	06500	RESPIRATORY THERAPY	17,194	11,113	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	49,153	23,832	1,711	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,849	0	428	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,689	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,798	0	1,447	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,133	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,659	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	188,872	32,607	13,824	12,167	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)	892,106	281,725	36,001	43,952	46,130	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	188	1,506	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,140	0	2,204	8,100	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MISSION SERVICES	2	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	894,436	283,231	38,205	52,052	46,130	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II Date/Time Prepared: 11/18/2021 4:43 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	48,575					11.00
13.00	01300	NURSING ADMINISTRATION	1,679	55,957				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	243	0	2,846			14.00
15.00	01500	PHARMACY	2,570	0	0	69,653		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	165,940	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,213	23,920	0	0	5,059	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,244	8,314	0	0	19,384	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,206	0	0	0	46,879	54.00
60.00	06000	LABORATORY	1,123	470	0	0	33,831	60.00
65.00	06500	RESPIRATORY THERAPY	2,153	0	0	0	1,937	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	8,245	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	2,063	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	781	68.00
69.00	06900	ELECTROCARDIOLOGY	1,343	334	0	0	7,060	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,846	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	69,653	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,801	22,919	0	0	40,701	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)	48,575	55,957	2,846	69,653	165,940	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
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MISSION SERVICES	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	48,575	55,957	2,846	69,653	165,940	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II Date/Time Prepared: 11/18/2021 4:43 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	297,458	0	297,458		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	133,482	0	133,482		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	200,272	0	200,272		54.00
60.00	06000	LABORATORY	190,721	0	190,721		60.00
65.00	06500	RESPIRATORY THERAPY	50,136	0	50,136		65.00
66.00	06600	PHYSICAL THERAPY	82,941	0	82,941		66.00
67.00	06700	OCCUPATIONAL THERAPY	17,340	0	17,340		67.00
68.00	06800	SPEECH PATHOLOGY	6,470	0	6,470		68.00
69.00	06900	ELECTROCARDIOLOGY	18,982	0	18,982		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,979	0	12,979		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,659	0	9,659		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69,653	0	69,653		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	373,942	0	373,942		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)	1,464,035	0	1,464,035		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,099	0	4,099		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,444	0	12,444		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	MISSION SERVICES	2	0	2		193.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,480,580	0	1,480,580		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/18/2021 4:43 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	82,473					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		82,473				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	3,513,901			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,796	30,796	401,253	-5,958,111	11,426,263	5.00
7.00	00700	OPERATION OF PLANT	16,925	16,925	0	0	1,165,823	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,769	1,769	0	0	71,167	8.00
9.00	00900	HOUSEKEEPING	981	981	0	0	432,248	9.00
10.00	01000	DIETARY	2,179	2,179	0	0	75,780	10.00
11.00	01100	CAFETERIA	1,236	1,236	0	0	329,256	11.00
13.00	01300	NURSING ADMINISTRATION	1,931	1,931	156,419	0	238,309	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	8,668	0	33,249	14.00
15.00	01500	PHARMACY	968	968	233,665	0	628,842	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,582	8,582	0	0	97,341	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,571	5,571	757,309	0	1,118,174	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,287	2,287	320,799	0	576,432	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,586	1,586	650,830	0	1,091,598	54.00
60.00	06000	LABORATORY	1,297	1,297	35,517	0	1,650,274	60.00
65.00	06500	RESPIRATORY THERAPY	1,564	1,564	129,704	0	219,651	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	627,924	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	189,691	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	72,672	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	75,478	0	112,390	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	129,448	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	123,394	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,589	4,589	744,259	0	2,412,831	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)	82,261	82,261	3,513,901	-5,958,111	11,396,494	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	212	212	0	0	2,405	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	27,334	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MISSION SERVICES	0	0	0	0	30	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	405,627	529,823	1,168,420		5,958,111	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.918301	6.424199	0.332514		0.521440	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		894,436	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.078279	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: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/18/2021 4:43 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	39,861					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,769	70,196				8.00
9.00	00900	HOUSEKEEPING	981	218	12,107			9.00
10.00	01000	DIETARY	2,179	0	0	100		10.00
11.00	01100	CAFETERIA	1,236	0	0	0	4,196	11.00
13.00	01300	NURSING ADMINISTRATION	1,931	0	0	0	145	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	21	14.00
15.00	01500	PHARMACY	968	0	0	0	222	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,582	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,571	12,304	3,055	100	1,055	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,287	8,963	1,942	0	453	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,341	12,672	1,887	0	968	54.00
60.00	06000	LABORATORY	1,297	0	509	0	97	60.00
65.00	06500	RESPIRATORY THERAPY	1,564	0	0	0	186	65.00
66.00	06600	PHYSICAL THERAPY	3,354	3,143	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	786	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,658	0	0	116	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,589	25,403	2,830	0	933	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)	39,649	66,147	10,223	100	4,196	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	212	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,049	1,884	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MISSION SERVICES	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,773,730	186,993	701,872	212,256	555,942	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	44.497880	2.663870	57.972413	2,122.560000	132.493327	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	283,231	38,205	52,052	46,130	48,575	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.105466	0.544262	4.299331	461.300000	11.576501	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: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/18/2021 4:43 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	42,340					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	100				14.00
15.00	01500	PHARMACY	0	0	1,000			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	52,263,690		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,098	0	0	1,593,271		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,291	0	0	6,105,226		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,764,468		54.00
60.00	06000	LABORATORY	356	0	0	10,655,452		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	610,001		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,596,770		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	649,653		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	246,072		68.00
69.00	06900	ELECTROCARDIOLOGY	253	0	0	2,223,716		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	100	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,000	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	17,342	0	0	12,819,061		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)	42,340	100	1,000	52,263,690		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	MISSION SERVICES	0	0	0	0		193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	467,710	53,368	1,029,233	529,978		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.046528	533.680000	1,029.233000	0.010140		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	55,957	2,846	69,653	165,940		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.321611	28.460000	69.653000	0.003175		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/18/2021 4:43 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,727,126		2,727,126	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,306,652		1,306,652	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,230,611		2,230,611	0	0	54.00
60.00	06000	LABORATORY	2,722,846		2,722,846	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	434,610	0	434,610	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,139,299	0	1,139,299	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	297,284	0	297,284	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	113,061	0	113,061	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	218,788		218,788	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	250,315		250,315	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	187,737		187,737	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,029,233		1,029,233	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,552,080		4,552,080	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	958,487		958,487		0	92.00
200.00		Subtotal (see instructions)	18,168,129	0	18,168,129	0	0	200.00
201.00		Less Observation Beds	958,487		958,487		0	201.00
202.00		Total (see instructions)	17,209,642	0	17,209,642	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/18/2021 4:43 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	832,120		832,120			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	142,009	5,963,217	6,105,226	0.214022	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	172,511	14,591,957	14,764,468	0.151080	0.000000	54.00
60.00	06000	LABORATORY	268,266	10,387,186	10,655,452	0.255535	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	297,153	312,848	610,001	0.712474	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	194,635	2,402,135	2,596,770	0.438737	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	117,456	532,197	649,653	0.457604	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	5,955	240,117	246,072	0.459463	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	41,716	2,182,000	2,223,716	0.098388	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	108,353	785,215	893,568	0.280130	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	41,330	193,551	234,881	0.799286	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	258,924	2,561,457	2,820,381	0.364927	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	59,490	12,759,571	12,819,061	0.355102	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	39,444	721,707	761,151	1.259260	0.000000	92.00
200.00		Subtotal (see instructions)	2,579,362	53,633,158	56,212,520			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,579,362	53,633,158	56,212,520			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/18/2021 4:43 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	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: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/18/2021 4:43 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,727,126		2,727,126	0	2,727,126	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,306,652		1,306,652	0	1,306,652	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,230,611		2,230,611	0	2,230,611	54.00
60.00	06000	LABORATORY	2,722,846		2,722,846	0	2,722,846	60.00
65.00	06500	RESPIRATORY THERAPY	434,610	0	434,610	0	434,610	65.00
66.00	06600	PHYSICAL THERAPY	1,139,299	0	1,139,299	0	1,139,299	66.00
67.00	06700	OCCUPATIONAL THERAPY	297,284	0	297,284	0	297,284	67.00
68.00	06800	SPEECH PATHOLOGY	113,061	0	113,061	0	113,061	68.00
69.00	06900	ELECTROCARDIOLOGY	218,788		218,788	0	218,788	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	250,315		250,315	0	250,315	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	187,737		187,737	0	187,737	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,029,233		1,029,233	0	1,029,233	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,552,080		4,552,080	0	4,552,080	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	958,487		958,487		958,487	92.00
200.00		Subtotal (see instructions)	18,168,129	0	18,168,129	0	18,168,129	200.00
201.00		Less Observation Beds	958,487		958,487		958,487	201.00
202.00		Total (see instructions)	17,209,642	0	17,209,642	0	17,209,642	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/18/2021 4:43 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	832,120		832,120			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	142,009	5,963,217	6,105,226	0.214022	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	172,511	14,591,957	14,764,468	0.151080	0.000000	54.00
60.00	06000	LABORATORY	268,266	10,387,186	10,655,452	0.255535	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	297,153	312,848	610,001	0.712474	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	194,635	2,402,135	2,596,770	0.438737	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	117,456	532,197	649,653	0.457604	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	5,955	240,117	246,072	0.459463	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	41,716	2,182,000	2,223,716	0.098388	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	108,353	785,215	893,568	0.280130	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	41,330	193,551	234,881	0.799286	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	258,924	2,561,457	2,820,381	0.364927	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	59,490	12,759,571	12,819,061	0.355102	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	39,444	721,707	761,151	1.259260	0.000000	92.00
200.00		Subtotal (see instructions)	2,579,362	53,633,158	56,212,520			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,579,362	53,633,158	56,212,520			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/18/2021 4:43 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part II Date/Time Prepared: 11/18/2021 4:43 pm

Title XVIII | Hospital | Cost

		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	133,482	6,105,226	0.021864	19,226	420	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	200,272	14,764,468	0.013564	58,980	800	54.00
60.00	06000	LABORATORY	190,721	10,655,452	0.017899	97,533	1,746	60.00
65.00	06500	RESPIRATORY THERAPY	50,136	610,001	0.082190	82,060	6,745	65.00
66.00	06600	PHYSICAL THERAPY	82,941	2,596,770	0.031940	22,229	710	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,340	649,653	0.026691	11,697	312	67.00
68.00	06800	SPEECH PATHOLOGY	6,470	246,072	0.026293	2,811	74	68.00
69.00	06900	ELECTROCARDIOLOGY	18,982	2,223,716	0.008536	3,506	30	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,979	893,568	0.014525	38,133	554	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,659	234,881	0.041123	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69,653	2,820,381	0.024696	77,243	1,908	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	373,942	12,819,061	0.029171	4,261	124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	104,546	761,151	0.137353	1,011	139	92.00
200.00		Total (lines 50 through 199)	1,271,123	55,380,400		418,690	13,562	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/18/2021 4:43 pm

Title XVIII | Hospital | Cost

		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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
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: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/18/2021 4:43 pm

Title XVIII | Hospital | Cost

		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	6,105,226	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,764,468	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	10,655,452	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	610,001	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,596,770	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	649,653	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	246,072	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,223,716	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	893,568	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	234,881	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,820,381	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	12,819,061	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	761,151	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	55,380,400		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/18/2021 4:43 pm

Title XVIII | Hospital | Cost

		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	19,226	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	58,980	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	97,533	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	82,060	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	22,229	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	11,697	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,811	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,506	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	38,133	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	77,243	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	4,261	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,011	0	0	0	92.00
200.00		Total (lines 50 through 199)		418,690	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/18/2021 4:43 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.214022	0	1,686,891	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151080	0	3,953,415	0	0	54.00
60.00	06000	LABORATORY	0.255535	0	2,866,209	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.712474	0	89,454	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.438737	0	673,884	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.457604	0	74,718	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.459463	0	17,052	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.098388	0	272,941	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.280130	0	193,682	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.799286	0	66,525	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.364927	0	1,308,110	2,683	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.355102	0	2,126,766	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.259260	0	217,915	0	0	92.00
200.00		Subtotal (see instructions)		0	13,547,562	2,683	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	13,547,562	2,683	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/18/2021 4:43 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	361,032	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	597,282	0		54.00
60.00	06000	LABORATORY	732,417	0		60.00
65.00	06500	RESPIRATORY THERAPY	63,734	0		65.00
66.00	06600	PHYSICAL THERAPY	295,658	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	34,191	0		67.00
68.00	06800	SPEECH PATHOLOGY	7,835	0		68.00
69.00	06900	ELECTROCARDIOLOGY	26,854	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	54,256	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	53,173	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	477,365	979		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	755,219	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	274,412	0		92.00
200.00		Subtotal (see instructions)	3,733,428	979		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,733,428	979		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1309 | Component CCN: 15-Z309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/18/2021 4:43 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.214022	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151080	0	0	0	0	54.00
60.00	06000	LABORATORY	0.255535	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.712474	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.438737	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.457604	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.459463	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.098388	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.280130	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.799286	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.364927	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.355102	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.259260	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	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	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1309 | Component CCN: 15-Z309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V | Date/Time Prepared: 11/18/2021 4:43 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: 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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/18/2021 4:43 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	956	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	575	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)	239	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	185	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)	196	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)	130	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)	147	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)	195	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	216.95	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	216.95	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,727,126	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)	1,086,856	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,640,270	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,640,270	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)	2,852.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	370,843	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)	370,843	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/18/2021 4:43 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	154,814	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	525,657	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	419,338	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	556,265	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	975,603	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)	336	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,852.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	958,487	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/18/2021 4:43 pm
	Title XVIII	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	297,458	2,727,126	0.109074	958,487	104,546	90.00
91.00	Nursing School cost	0	2,727,126	0.000000	958,487	0	91.00
92.00	Allied health cost	0	2,727,126	0.000000	958,487	0	92.00
93.00	All other Medical Education	0	2,727,126	0.000000	958,487	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/18/2021 4:43 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	956	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	575	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)	239	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	185	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)	196	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	216.95	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	216.95	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,727,126	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)	1,086,856	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,640,270	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,640,270	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)	2,852.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/18/2021 4:43 pm

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	0	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	336	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,852.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	958,487	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/18/2021 4:43 pm
	Title XIX	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	297,458	2,727,126	0.109074	958,487	104,546	90.00
91.00	Nursing School cost	0	2,727,126	0.000000	958,487	0	91.00
92.00	Allied health cost	0	2,727,126	0.000000	958,487	0	92.00
93.00	All other Medical Education	0	2,727,126	0.000000	958,487	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 11/18/2021 4:43 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		260,840		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.214022	19,226	4,115	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151080	58,980	8,911	54.00
60.00	06000	LABORATORY	0.255535	97,533	24,923	60.00
65.00	06500	RESPIRATORY THERAPY	0.712474	82,060	58,466	65.00
66.00	06600	PHYSICAL THERAPY	0.438737	22,229	9,753	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.457604	11,697	5,353	67.00
68.00	06800	SPEECH PATHOLOGY	0.459463	2,811	1,292	68.00
69.00	06900	ELECTROCARDIOLOGY	0.098388	3,506	345	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.280130	38,133	10,682	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.799286	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.364927	77,243	28,188	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.355102	4,261	1,513	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.259260	1,011	1,273	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		418,690	154,814	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)		418,690		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1309 | Component CCN: 15-Z309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 11/18/2021 4:43 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.214022	13,676	2,927	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151080	17,170	2,594	54.00
60.00	06000	LABORATORY	0.255535	59,936	15,316	60.00
65.00	06500	RESPIRATORY THERAPY	0.712474	137,791	98,173	65.00
66.00	06600	PHYSICAL THERAPY	0.438737	140,044	61,442	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.457604	86,844	39,740	67.00
68.00	06800	SPEECH PATHOLOGY	0.459463	2,346	1,078	68.00
69.00	06900	ELECTROCARDIOLOGY	0.098388	804	79	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.280130	32,488	9,101	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.799286	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.364927	74,123	27,049	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.355102	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.259260	268	337	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		565,490	257,836	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)		565,490		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 11/18/2021 4:43 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.214022	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151080	0	0	54.00
60.00	06000	LABORATORY	0.255535	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.712474	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.438737	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.457604	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.459463	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.098388	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.280130	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.799286	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.364927	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.355102	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.259260	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/18/2021 4:43 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,734,407	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,734,407	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	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)	3,771,751	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	43,779	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,066,664	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,661,308	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,661,308	30.00
31.00	Primary payer payments	1,426	31.00
32.00	Subtotal (line 30 minus line 31)	1,659,882	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)	320,177	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	208,115	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	268,971	36.00
37.00	Subtotal (see instructions)	1,867,997	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,867,997	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	1,817,587	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)	50,410	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: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-1 Part I Date/Time Prepared: 11/18/2021 4:43 pm

Title XVIII | Hospital | Cost

		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		404,337		1,817,587	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)		404,337		1,817,587	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		81,379		50,410	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		485,716		1,867,997	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1309 | Component CCN: 15-Z309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-1 Part I | Date/Time Prepared: 11/18/2021 4:43 pm

Title XVIII | Swing Beds - SNF | Cost

		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		985,777		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		985,777		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		252,947		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,238,724		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part II Date/Time Prepared: 11/18/2021 4:43 pm
	Title XVIII	Hospital	Cost

			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 - SWING BEDS | Provider CCN: 15-1309 | Component CCN: 15-Z309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-2 | Date/Time Prepared: 11/18/2021 4:43 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	985,359	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	260,414	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	342	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,245,773	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,245,773	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,245,773	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,049	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,238,724	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,238,724	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	985,777	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	252,947	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part V Date/Time Prepared: 11/18/2021 4:43 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	525,657	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	525,657	4.00
5.00	Primary payer payments	18,525	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	512,389	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	512,389	19.00
20.00	Deductibles (exclude professional component)	27,588	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	484,801	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	484,801	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1,408	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	915	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	485,716	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	485,716	30.00
30.01	Sequestration adjustment (see instructions)	0	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	404,337	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	81,379	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/18/2021 4:43 pm
	Title XIX	Hospital	Cost

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G | Date/Time Prepared: 11/18/2021 4:43 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	226	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,249,431	0	0	0	4.00
5.00	Other receivable	803,975	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,202,222	0	0	0	6.00
7.00	Inventory	317,621	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	-3,159	0	0	0	9.00
10.00	Due from other funds	287,318	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,453,190	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,500	0	0	0	12.00
13.00	Land improvements	458,231	0	0	0	13.00
14.00	Accumulated depreciation	-224,856	0	0	0	14.00
15.00	Buildings	10,714,459	0	0	0	15.00
16.00	Accumulated depreciation	-5,426,872	0	0	0	16.00
17.00	Leasehold improvements	995,040	0	0	0	17.00
18.00	Accumulated depreciation	-669,124	0	0	0	18.00
19.00	Fixed equipment	3,131,335	0	0	0	19.00
20.00	Accumulated depreciation	-2,645,194	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	7,971,049	0	0	0	23.00
24.00	Accumulated depreciation	-6,949,759	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,356,809	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	0	2,006,130	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	2,006,130	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,809,999	2,006,130	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	347,561	0	0	0	37.00
38.00	Salaries, wages, and fees payable	621,263	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	114,037	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	0	0	0	0	43.00
44.00	Other current liabilities	4,312,304	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,395,165	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,982,771	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	80,595	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,063,366	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,458,531	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-1,648,532				52.00
53.00	Specific purpose fund		2,006,130			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)	-1,648,532	2,006,130	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,809,999	2,006,130	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G-1 | Date/Time Prepared: 11/18/2021 4:43 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		-1,904,870		1,694,245		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,094,714				2.00
3.00	Total (sum of line 1 and line 2)		-810,156		1,694,245		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	Contributions	0		10,146		0	5.00
6.00	Restricted Invest. Income - HSD	0		156,547		0	6.00
7.00		0		0		0	7.00
8.00	Transfer from Affiliates	-838,372		0		0	8.00
9.00	Rounding	-4		0		0	9.00
10.00	Total additions (sum of line 4-9)		-838,376		166,693		10.00
11.00	Subtotal (line 3 plus line 10)		-1,648,532		1,860,938		11.00
12.00	Transfer from Affiliates	0		3,672		0	12.00
13.00		0		0		0	13.00
14.00	Restricted Invest. Income - HSD	0		-148,864		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		-145,192		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-1,648,532		2,006,130		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	Contributions		0			5.00
6.00	Restricted Invest. Income - HSD		0			6.00
7.00			0			7.00
8.00	Transfer from Affiliates		0			8.00
9.00	Rounding		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	Transfer from Affiliates		0			12.00
13.00			0			13.00
14.00	Restricted Invest. Income - HSD		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: 15-1309 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/18/2021 4:43 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,952,933		1,952,933	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,952,933		1,952,933	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,952,933		1,952,933	17.00
18.00	Ancillary services	1,648,410	39,046,197	40,694,607	18.00
19.00	Outpatient services	98,934	13,466,910	13,565,844	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	Other Patient Service Revenue	0	214	214	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,700,277	52,513,321	56,213,598	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,122,342		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)		18,122,342		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet G-3 Date/Time Prepared: 11/18/2021 4:43 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	56,213,598	1.00
2.00	Less contractual allowances and discounts on patients' accounts	37,639,632	2.00
3.00	Net patient revenues (line 1 minus line 2)	18,573,966	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	18,122,342	4.00
5.00	Net income from service to patients (line 3 minus line 4)	451,624	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	31,709	6.00
7.00	Income from investments	130	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	28,573	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	41	17.00
18.00	Revenue from sale of medical records and abstracts	148	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	170,684	22.00
23.00	Governmental appropriations	0	23.00
24.00	Misc. Income	10,302	24.00
24.01	Assets Released from Restriction	3,672	24.01
24.50	COVID-19 PHE Funding	397,831	24.50
25.00	Total other income (sum of lines 6-24)	643,090	25.00
26.00	Total (line 5 plus line 25)	1,094,714	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,094,714	29.00