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: 15-1326	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/26/2022 10:52 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/26/2022 Time: 10:52 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by UNION HOSPITAL CLINTON (15-1326) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-83,165	-1,047,653	0	-36,035	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	-22,716	18		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-105,881	-1,047,635	0	-36,035	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: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 10:52 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 801 SOUTH MAIN STREET	PO Box:			1.00
2.00	City: CLINTON	State: IN	Zip Code: 47842-	County: VERMILLION	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	UNION HOSPITAL CLINTON	151326	45460	1	03/01/2005	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	SWING BEDS	15Z326	45460		03/01/2005	N	O	O	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2021	12/31/2021	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 10:52 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1326	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 10:52 am

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 10:52 am

		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: 15-1326	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 10:52 am

		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.	Y	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	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.	N	N	N	N	109.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 10:52 am

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	83,947	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	5.06	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	15H043	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 10:52 am

		1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name: UNION HOSPITAL, INC.	Contractor's Name: WPS		Contractor's Number: 08101	141.00
142.00	Street: 1606 NORTH SEVENTH ST	PO Box:			142.00
143.00	City: TERRE HAUTE	State: IN		Zip Code: 47804	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: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2022 10:52 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/10/2022	Y	03/10/2022	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 10:52 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	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.	CAROLYN		CHAPLIN		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3177137919		CCHAPLIN@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1326	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 10:52 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR 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: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 10:52 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	728,905.00	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	728,905.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	728,905.00	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: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 10:52 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	821	27	1,976			1.00
2.00	HMO and other (see instructions)	211	16				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	495	0	495			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	157			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,316	27	2,628			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,316	27	2,628	0.00	112.85	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	112.85	27.00
28.00	Observation Bed Days		182	890			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 10:52 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	277	10	653	1.00
2.00	HMO and other (see instructions)			58	4		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	277	10	653	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: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-10 | Date/Time Prepared: 5/26/2022 10:52 am

		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)	0.297077	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,049,926	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	23,107,386	6.00
7.00	Medicaid cost (line 1 times line 6)	6,864,673	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)	814,747	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)	814,747	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)	1,228,253	178,961	1,407,214	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	364,886	178,961	543,847	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	364,886	178,961	543,847	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)	2,496,002	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	97,740	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	150,370	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,345,632	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	749,463	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,293,310	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,108,057	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/26/2022 10:52 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		731,981	731,981	-20,165	711,816	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		382,039	382,039	-732	381,307	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	665	665	0	665	5.01
5.02	00550	DATA PROCESSING	0	370,514	370,514	0	370,514	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	68,892	68,892	0	68,892	5.03
5.04	00570	ADMITTING	448,253	58,842	507,095	0	507,095	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,052	163,272	166,324	0	166,324	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	1,245,159	2,155,151	3,400,310	0	3,400,310	5.06
7.00	00700	OPERATION OF PLANT	409,205	763,693	1,172,898	0	1,172,898	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	225,451	66,355	291,806	0	291,806	9.00
10.00	01000	DIETARY	366,821	217,096	583,917	-404,836	179,081	10.00
11.00	01100	CAFETERIA	0	0	0	404,836	404,836	11.00
13.00	01300	NURSING ADMINISTRATION	759,606	91,228	850,834	0	850,834	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	110,681	70,301	180,982	0	180,982	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,885,204	719,312	2,604,516	0	2,604,516	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	344,217	306,380	650,597	-120,946	529,651	50.00
51.00	05100	RECOVERY ROOM	5,895	639	6,534	137,620	144,154	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	774,938	604,764	1,379,702	0	1,379,702	54.00
56.00	05600	RADIOISOTOPE	38,271	28,203	66,474	0	66,474	56.00
60.00	06000	LABORATORY	285,915	652,936	938,851	0	938,851	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	24,950	24,950	0	24,950	62.00
65.00	06500	RESPIRATORY THERAPY	559,490	133,600	693,090	-351,008	342,082	65.00
66.00	06600	PHYSICAL THERAPY	0	803,367	803,367	0	803,367	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,266	10,266	0	10,266	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,535	11,535	0	11,535	68.00
69.00	06900	ELECTROCARDIOLOGY	3,941	88,878	92,819	392,749	485,568	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	72,364	72,364	-72,364	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,492	15,492	0	15,492	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	259,530	1,030,422	1,289,952	0	1,289,952	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	882,220	2,433,303	3,315,523	13,949	3,329,472	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)	8,607,849	12,076,440	20,684,289	-20,897	20,663,392	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	20,897	20,897	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	8,607,849	12,076,440	20,684,289	0	20,684,289	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/26/2022 10:52 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	759,229	1,471,045		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	381,307		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,417,979	1,417,979		4.00
5.01	00540	NONPATIENT TELEPHONES	26,700	27,365		5.01
5.02	00550	DATA PROCESSING	3,929,872	4,300,386		5.02
5.03	00560	PURCHASING RECEIVING AND STORES	64,891	133,783		5.03
5.04	00570	ADMITTING	0	507,095		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	445,121	611,445		5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	-247,867	3,152,443		5.06
7.00	00700	OPERATION OF PLANT	717,341	1,890,239		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		8.00
9.00	00900	HOUSEKEEPING	33,045	324,851		9.00
10.00	01000	DIETARY	11,644	190,725		10.00
11.00	01100	CAFETERIA	-83,646	321,190		11.00
13.00	01300	NURSING ADMINISTRATION	83,471	934,305		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,056	205,038		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-662,083	1,942,433		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-40,837	488,814		50.00
51.00	05100	RECOVERY ROOM	1,989	146,143		51.00
51.01	05101	O/P TREATMENT ROOM	0	0		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	70,156	1,449,858		54.00
56.00	05600	RADIOISOTOPE	0	66,474		56.00
60.00	06000	LABORATORY	0	938,851		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	24,950		62.00
65.00	06500	RESPIRATORY THERAPY	0	342,082		65.00
66.00	06600	PHYSICAL THERAPY	-328,711	474,656		66.00
67.00	06700	OCCUPATIONAL THERAPY	114,185	124,451		67.00
68.00	06800	SPEECH PATHOLOGY	-401	11,134		68.00
69.00	06900	ELECTROCARDIOLOGY	765	486,333		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,492		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,864	1,372,816		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-10,000	3,319,472		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)	6,409,763	27,073,155		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	PHYSICIAN PRACTICES	0	0		194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	20,897		194.01
194.02	07952	VPCHC	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	6,409,763	27,094,052		200.00

RECLASSIFICATIONS | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 10:52 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	254,321	150,515		1.00
	0		254,321	150,515		
	B - DEPRECIATION RECLASS					
1.00	MEDICAL OFFICE BUILDING	194.01	0	20,897		1.00
2.00		0.00	0	0		2.00
	0		0	20,897		
	C - CENTRAL SUPPLIES RECLASS					
1.00	OPERATING ROOM	50.00	0	16,674		1.00
2.00	RESPIRATORY THERAPY	65.00	0	41,741		2.00
3.00	EMERGENCY	91.00	0	13,949		3.00
	0		0	72,364		
	D - RECOVERY ROOM					
1.00	RECOVERY ROOM	51.00	78,013	59,607		1.00
	0		78,013	59,607		
	E - EKG RECLASS					
1.00	ELECTROCARDIOLOGY	69.00	317,043	75,706		1.00
	TOTALS		317,043	75,706		
500.00	Grand Total: Increases		649,377	379,089		500.00

RECLASSIFICATIONS | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 10:52 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	254,321	150,515	0		1.00
	0		254,321	150,515			
	B - DEPRECIATION RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	20,165	9		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	732	9		2.00
	0		0	20,897			
	C - CENTRAL SUPPLIES RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	72,364	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	72,364			
	D - RECOVERY ROOM						
1.00	OPERATING ROOM	50.00	78,013	59,607	0		1.00
	0		78,013	59,607			
	E - EKG RECLASS						
1.00	RESPIRATORY THERAPY	65.00	317,043	75,706	0		1.00
	TOTALS		317,043	75,706			
500.00	Grand Total: Decreases		649,377	379,089			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2022 10:52 am

		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	339,822	0	0	0	0	1.00
2.00	Land Improvements	374,328	6,375	0	6,375	0	2.00
3.00	Buildings and Fixtures	12,116,371	1,849,877	0	1,849,877	0	3.00
4.00	Building Improvements	1,645,471	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	7,368,470	602,158	0	602,158	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	21,844,462	2,458,410	0	2,458,410	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	21,844,462	2,458,410	0	2,458,410	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	339,822	0	1.00
2.00	Land Improvements	380,703	0	2.00
3.00	Buildings and Fixtures	13,966,248	0	3.00
4.00	Building Improvements	1,645,471	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	7,970,628	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,302,872	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	24,302,872	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II | Date/Time Prepared: 5/26/2022 10:52 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	731,981	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	382,039	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,114,020	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	731,981		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	382,039		2.00
3.00	Total (sum of lines 1-2)	0	1,114,020		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III Date/Time Prepared: 5/26/2022 10:52 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	16,332,244	0	16,332,244	0.672029	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	7,970,628	0	7,970,628	0.327971	0	2.00
3.00	Total (sum of lines 1-2)	24,302,872	0	24,302,872	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,471,045	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	381,307	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,852,352	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,471,045	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	381,307	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,852,352	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/26/2022 10:52 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	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	-771,504			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	8,927,969			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW 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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/26/2022 10:52 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-894	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	MISCELLANEOUS REVENUE	B	-86,112	ADMINISTRATIVE AND GENERAL	5.06	0	33.00
33.01	CAFETERIA REVENUE	B	-111,293	CAFETERIA	11.00	0	33.01
33.02	VPCHC	B	-5,650	HOUSEKEEPING	9.00	0	33.02
33.03	ADVERTISING	A	-1,325	ADMINISTRATIVE AND GENERAL	5.06	0	33.03
33.04	RENTAL REVENUE	B	0	OPERATION OF PLANT	7.00	0	33.04
33.05	HAF	A	-1,509,206	ADMINISTRATIVE AND GENERAL	5.06	0	33.05
35.00	PHYSICIAN RECRUITMENT	A	-22,222	ADMINISTRATIVE AND GENERAL	5.06	0	35.00
36.00	PHYSICIAN RECRUITMENT	A	-10,000	EMERGENCY	91.00	0	36.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		6,409,763				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: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2022 10:52 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE	760,123	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,417,979	0	2.00
3.00	5.01	NONPATIENT TELEPHONES	HOME OFFICE	26,700	0	3.00
3.01	5.02	DATA PROCESSING	HOME OFFICE	3,929,872	0	3.01
4.00	5.03	PURCHASING RECEIVING AND STO	HOME OFFICE	64,891	0	4.00
4.01	5.05	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	445,121	0	4.01
4.02	5.06	ADMINISTRATIVE AND GENERAL	HOME OFFICE	1,370,998	0	4.02
4.03	7.00	OPERATION OF PLANT	HOME OFFICE	717,341	0	4.03
4.04	9.00	HOUSEKEEPING	HOME OFFICE	38,695	0	4.04
4.05	10.00	DIETARY	HOME OFFICE	11,644	0	4.05
4.06	11.00	CAFETERIA	HOME OFFICE	27,647	0	4.06
4.07	13.00	NURSING ADMINISTRATION	HOME OFFICE	83,471	0	4.07
4.08	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	24,056	0	4.08
4.09	50.00	OPERATING ROOM	HOME OFFICE	6,744	0	4.09
4.10	50.00	OPERATING ROOM	HOME OFFICE	10,652	0	4.10
4.11	51.00	RECOVERY ROOM	HOME OFFICE	1,989	0	4.11
4.12	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	121,344	0	4.12
4.13	66.00	PHYSICAL THERAPY	HOME OFFICE	28,012	0	4.13
4.14	67.00	OCCUPATIONAL THERAPY	HOME OFFICE	8,450	0	4.14
4.15	68.00	SPEECH PATHOLOGY	HOME OFFICE	732	0	4.15
4.16	69.00	ELECTROCARDIOLOGY	HOME OFFICE	765	0	4.16
4.17	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	82,864	0	4.17
4.18	66.00	PHYSICAL THERAPY	THERAPY	350,520	707,243	4.18
4.19	67.00	OCCUPATIONAL THERAPY	THERAPY	105,735	0	4.19
4.20	68.00	SPEECH PATHOLOGY	THERAPY	9,163	10,296	4.20
5.00	0		0	9,645,508	717,539	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		0.00	UNION HOSPITAL	100.00	6.00
7.00	G		0.00	UNION THERAPY	51.00	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:	OTHER				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: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2022 10:52 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	760,123	9		1.00
2.00	1,417,979	0		2.00
3.00	26,700	0		3.00
3.01	3,929,872	0		3.01
4.00	64,891	0		4.00
4.01	445,121	0		4.01
4.02	1,370,998	0		4.02
4.03	717,341	0		4.03
4.04	38,695	0		4.04
4.05	11,644	0		4.05
4.06	27,647	0		4.06
4.07	83,471	0		4.07
4.08	24,056	0		4.08
4.09	6,744	0		4.09
4.10	10,652	0		4.10
4.11	1,989	0		4.11
4.12	121,344	0		4.12
4.13	28,012	0		4.13
4.14	8,450	0		4.14
4.15	732	0		4.15
4.16	765	0		4.16
4.17	82,864	0		4.17
4.18	-356,723	0		4.18
4.19	105,735	0		4.19
4.20	-1,133	0		4.20
5.00	8,927,969			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	HOME OFFICE		6.00
7.00	THERAPY		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: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2022 10:52 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	662,083	662,083	0	0	0	1.00
2.00	50.00	OPERATING ROOM	58,233	58,233	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	51,188	51,188	0	0	0	3.00
4.00	91.00	EMERGENCY	1,964,343	0	1,964,343	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			2,735,847	771,504	1,964,343		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	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	30.00	ADULTS & PEDIATRICS	0	0	0	662,083		1.00
2.00	50.00	OPERATING ROOM	0	0	0	58,233		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	51,188		3.00
4.00	91.00	EMERGENCY	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	771,504		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 10:52 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,471,045	1,471,045				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	381,307		381,307			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,417,979	0	0	1,417,979		4.00
5.01	00540	NONPATIENT TELEPHONES	27,365	1,973	4,039	0	33,377	5.01
5.02	00550	DATA PROCESSING	4,300,386	3,852	132,293	0	528	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	133,783	15,008	0	0	264	5.03
5.04	00570	ADMITTING	507,095	9,563	611	73,841	923	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	611,445	5,654	0	503	660	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	3,152,443	27,967	1,063	205,116	1,847	5.06
7.00	00700	OPERATION OF PLANT	1,890,239	407,667	5,388	67,409	2,902	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,855	130	0	0	8.00
9.00	00900	HOUSEKEEPING	324,851	7,438	1,559	37,139	132	9.00
10.00	01000	DIETARY	190,725	25,975	1,741	18,532	264	10.00
11.00	01100	CAFETERIA	321,190	58,723	5,223	41,895	660	11.00
13.00	01300	NURSING ADMINISTRATION	934,305	26,222	202	125,131	528	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	205,038	16,602	56	18,233	1,055	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,942,433	273,182	19,007	310,550	9,760	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	488,814	61,076	36,595	43,852	792	50.00
51.00	05100	RECOVERY ROOM	146,143	36,221	4,575	13,822	1,847	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,449,858	108,245	104,642	127,656	2,111	54.00
56.00	05600	RADIOISOTOPE	66,474	0	24,191	6,304	0	56.00
60.00	06000	LABORATORY	938,851	32,464	3,535	47,099	792	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	24,950	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	342,082	30,548	9,443	39,939	792	65.00
66.00	06600	PHYSICAL THERAPY	474,656	64,112	23	0	1,319	66.00
67.00	06700	OCCUPATIONAL THERAPY	124,451	53,923	0	0	923	67.00
68.00	06800	SPEECH PATHOLOGY	11,134	7,286	0	0	264	68.00
69.00	06900	ELECTROCARDIOLOGY	486,333	7,950	2,548	52,876	528	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,492	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,372,816	19,239	764	42,753	792	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,319,472	162,300	23,541	145,329	3,694	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)	27,073,155	1,471,045	381,169	1,417,979	33,377	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	138	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	20,897	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	27,094,052	1,471,045	381,307	1,417,979	33,377	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/26/2022 10:52 am

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	4,437,059					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	61,201	210,256				5.03
5.04	00570	ADMITTING	214,203	3,567	809,803			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	30,600	0	0	648,862		5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	306,004	16	0	0	3,694,456	5.06
7.00	00700	OPERATION OF PLANT	214,203	61	0	0	2,587,869	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	7,985	8.00
9.00	00900	HOUSEKEEPING	61,201	16,071	0	0	448,391	9.00
10.00	01000	DIETARY	61,201	20	0	0	298,458	10.00
11.00	01100	CAFETERIA	91,801	47	0	0	519,539	11.00
13.00	01300	NURSING ADMINISTRATION	61,201	5	0	0	1,147,594	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	91,801	21	0	0	332,806	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,071,014	51,117	395,978	50,190	4,123,231	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	428,406	42,660	20,383	26,923	1,149,501	50.00
51.00	05100	RECOVERY ROOM	0	0	204	8,144	210,956	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	428,406	22,133	56,960	190,871	2,490,882	54.00
56.00	05600	RADIOISOTOPE	0	107	960	4,029	102,065	56.00
60.00	06000	LABORATORY	0	59	93,815	83,219	1,199,834	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1,000	201	26,151	62.00
65.00	06500	RESPIRATORY THERAPY	244,803	9,579	49,300	21,120	747,606	65.00
66.00	06600	PHYSICAL THERAPY	183,602	343	14,140	15,250	753,445	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	7,455	4,600	191,352	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	911	399	19,994	68.00
69.00	06900	ELECTROCARDIOLOGY	61,201	0	11,566	27,618	650,620	69.00
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	283	15,775	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	244,803	641	116,429	53,508	1,851,745	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	581,408	63,809	40,702	162,507	4,502,762	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)	4,437,059	210,256	809,803	648,862	27,073,017	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	138	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	20,897	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,437,059	210,256	809,803	648,862	27,094,052	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 10:52 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	3,694,456					5.06
7.00	00700	OPERATION OF PLANT	408,586	2,996,455				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,261	23,552	32,798			8.00
9.00	00900	HOUSEKEEPING	70,794	22,301	3,175	544,661		9.00
10.00	01000	DIETARY	47,122	77,882	284	14,377	438,123	10.00
11.00	01100	CAFETERIA	82,027	176,075	641	32,502	0	11.00
13.00	01300	NURSING ADMINISTRATION	181,188	78,622	0	14,513	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	52,545	49,779	0	9,189	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	650,996	819,104	10,976	151,201	438,123	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	181,489	183,129	896	33,804	0	50.00
51.00	05100	RECOVERY ROOM	33,307	108,603	0	20,047	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	393,273	324,558	3,502	59,911	0	54.00
56.00	05600	RADIOISOTOPE	16,115	0	0	0	0	56.00
60.00	06000	LABORATORY	189,436	97,339	0	17,968	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,129	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	118,036	91,593	238	16,907	0	65.00
66.00	06600	PHYSICAL THERAPY	118,958	192,231	2,603	35,485	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,212	161,681	0	29,845	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,157	21,846	0	4,033	0	68.00
69.00	06900	ELECTROCARDIOLOGY	102,723	23,837	732	4,400	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,491	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	292,363	57,686	0	10,649	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	710,927	486,637	9,751	89,830	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)	3,691,135	2,996,455	32,798	544,661	438,123	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	22	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	3,299	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,694,456	2,996,455	32,798	544,661	438,123	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 10:52 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL						5.06
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	810,784					11.00
13.00	01300	NURSING ADMINISTRATION	82,920	1,504,837				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,393	0	469,712			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	210,850	868,297	36,333	7,309,111	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	58,730	0	19,490	1,627,039	0	50.00
51.00	05100	RECOVERY ROOM	1,083	0	5,896	379,892	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	126,004	0	138,163	3,536,293	0	54.00
56.00	05600	RADIOISOTOPE	5,656	0	2,917	126,753	0	56.00
60.00	06000	LABORATORY	55,601	0	60,244	1,620,422	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	146	30,426	0	62.00
65.00	06500	RESPIRATORY THERAPY	31,411	0	15,289	1,021,080	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	11,040	1,113,762	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,330	416,420	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	289	49,319	0	68.00
69.00	06900	ELECTROCARDIOLOGY	41,520	0	19,993	843,825	0	69.00
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	205	18,471	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,586	0	38,735	2,287,764	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	135,030	636,540	117,642	6,689,119	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)	810,784	1,504,837	469,712	27,069,696	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	160	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	24,196	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	810,784	1,504,837	469,712	27,094,052	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 10:52 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00560	PURCHASING RECEIVING AND STORES			5.03
5.04	00570	ADMITTING			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.05
5.06	00591	ADMINISTRATIVE AND GENERAL			5.06
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	7,309,111		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,627,039		50.00
51.00	05100	RECOVERY ROOM	379,892		51.00
51.01	05101	O/P TREATMENT ROOM	0		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,536,293		54.00
56.00	05600	RADIOISOTOPE	126,753		56.00
60.00	06000	LABORATORY	1,620,422		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	30,426		62.00
65.00	06500	RESPIRATORY THERAPY	1,021,080		65.00
66.00	06600	PHYSICAL THERAPY	1,113,762		66.00
67.00	06700	OCCUPATIONAL THERAPY	416,420		67.00
68.00	06800	SPEECH PATHOLOGY	49,319		68.00
69.00	06900	ELECTROCARDIOLOGY	843,825		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,471		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,287,764		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	6,689,119		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)	27,069,696		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	PHYSICIAN PRACTICES	160		194.00
194.01	07951	MEDICAL OFFICE BUILDING	24,196		194.01
194.02	07952	VPCHC	0		194.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	27,094,052		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/26/2022 10:52 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	1,973	4,039	6,012	0	5.01
5.02	00550	DATA PROCESSING	0	3,852	132,293	136,145	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	15,008	0	15,008	0	5.03
5.04	00570	ADMITTING	0	9,563	611	10,174	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	5,654	0	5,654	0	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	0	27,967	1,063	29,030	0	5.06
7.00	00700	OPERATION OF PLANT	0	407,667	5,388	413,055	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,855	130	7,985	0	8.00
9.00	00900	HOUSEKEEPING	0	7,438	1,559	8,997	0	9.00
10.00	01000	DIETARY	0	25,975	1,741	27,716	0	10.00
11.00	01100	CAFETERIA	0	58,723	5,223	63,946	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	26,222	202	26,424	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,602	56	16,658	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	273,182	19,007	292,189	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	61,076	36,595	97,671	0	50.00
51.00	05100	RECOVERY ROOM	0	36,221	4,575	40,796	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	108,245	104,642	212,887	0	54.00
56.00	05600	RADIOISOTOPE	0	0	24,191	24,191	0	56.00
60.00	06000	LABORATORY	0	32,464	3,535	35,999	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	30,548	9,443	39,991	0	65.00
66.00	06600	PHYSICAL THERAPY	0	64,112	23	64,135	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	53,923	0	53,923	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,286	0	7,286	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,950	2,548	10,498	0	69.00
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	19,239	764	20,003	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	162,300	23,541	185,841	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)	0	1,471,045	381,169	1,852,214	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	138	138	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,471,045	381,307	1,852,352	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 10:52 am

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	6,012					5.01
5.02	00550	DATA PROCESSING	95	136,240				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	48	1,879	16,935			5.03
5.04	00570	ADMITTING	166	6,577	287	17,204		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	119	940	0	0	6,713	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	333	9,396	1	0	0	5.06
7.00	00700	OPERATION OF PLANT	523	6,577	5	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	24	1,879	1,294	0	0	9.00
10.00	01000	DIETARY	48	1,879	2	0	0	10.00
11.00	01100	CAFETERIA	119	2,819	4	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	95	1,879	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	190	2,819	2	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,755	32,885	4,117	8,415	518	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	143	13,154	3,436	433	278	50.00
51.00	05100	RECOVERY ROOM	333	0	0	4	84	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	380	13,154	1,783	1,210	1,987	54.00
56.00	05600	RADIOISOTOPE	0	0	9	20	42	56.00
60.00	06000	LABORATORY	143	0	5	1,993	859	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	21	2	62.00
65.00	06500	RESPIRATORY THERAPY	143	7,517	772	1,047	218	65.00
66.00	06600	PHYSICAL THERAPY	238	5,638	28	300	157	66.00
67.00	06700	OCCUPATIONAL THERAPY	166	0	0	158	47	67.00
68.00	06800	SPEECH PATHOLOGY	48	0	0	19	4	68.00
69.00	06900	ELECTROCARDIOLOGY	95	1,879	0	246	285	69.00
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	3	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	143	7,517	52	2,473	552	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	665	17,852	5,138	865	1,677	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)	6,012	136,240	16,935	17,204	6,713	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,012	136,240	16,935	17,204	6,713	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 10:52 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	38,760					5.06
7.00	00700	OPERATION OF PLANT	4,286	424,446				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13	3,336	11,334			8.00
9.00	00900	HOUSEKEEPING	743	3,159	1,097	17,193		9.00
10.00	01000	DIETARY	494	11,032	98	454	41,723	10.00
11.00	01100	CAFETERIA	860	24,941	221	1,026	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,900	11,137	0	458	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	551	7,051	0	290	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,828	116,027	3,795	4,773	41,723	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,904	25,940	309	1,067	0	50.00
51.00	05100	RECOVERY ROOM	349	15,384	0	633	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,125	45,973	1,210	1,891	0	54.00
56.00	05600	RADIOISOTOPE	169	0	0	0	0	56.00
60.00	06000	LABORATORY	1,987	13,788	0	567	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	43	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,238	12,974	82	534	0	65.00
66.00	06600	PHYSICAL THERAPY	1,248	27,229	899	1,120	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	317	22,902	0	942	0	67.00
68.00	06800	SPEECH PATHOLOGY	33	3,094	0	127	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,077	3,376	253	139	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,066	8,171	0	336	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,468	68,932	3,370	2,836	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)	38,725	424,446	11,334	17,193	41,723	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	35	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,760	424,446	11,334	17,193	41,723	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 10:52 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL						5.06
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	93,936					11.00
13.00	01300	NURSING ADMINISTRATION	9,607	51,500				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,942	0	30,503			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,430	29,716	2,363	569,534	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,804	0	1,267	152,406	0	50.00
51.00	05100	RECOVERY ROOM	125	0	383	58,091	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,599	0	8,944	308,143	0	54.00
56.00	05600	RADIOISOTOPE	655	0	190	25,276	0	56.00
60.00	06000	LABORATORY	6,442	0	3,917	65,700	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	9	75	0	62.00
65.00	06500	RESPIRATORY THERAPY	3,639	0	994	69,149	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	718	101,710	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	217	78,672	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	19	10,630	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,810	0	1,300	23,958	0	69.00
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	13	42	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,239	0	2,519	49,071	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	15,644	21,784	7,650	339,722	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)	93,936	51,500	30,503	1,852,179	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	138	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	35	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	93,936	51,500	30,503	1,852,352	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 10:52 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00560	PURCHASING RECEIVING AND STORES			5.03
5.04	00570	ADMITTING			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.05
5.06	00591	ADMINISTRATIVE AND GENERAL			5.06
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	569,534		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	152,406		50.00
51.00	05100	RECOVERY ROOM	58,091		51.00
51.01	05101	O/P TREATMENT ROOM	0		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	308,143		54.00
56.00	05600	RADIOISOTOPE	25,276		56.00
60.00	06000	LABORATORY	65,700		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	75		62.00
65.00	06500	RESPIRATORY THERAPY	69,149		65.00
66.00	06600	PHYSICAL THERAPY	101,710		66.00
67.00	06700	OCCUPATIONAL THERAPY	78,672		67.00
68.00	06800	SPEECH PATHOLOGY	10,630		68.00
69.00	06900	ELECTROCARDIOLOGY	23,958		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,071		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	339,722		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,852,179		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	PHYSICIAN PRACTICES	138		194.00
194.01	07951	MEDICAL OFFICE BUILDING	35		194.01
194.02	07952	VPCHC	0		194.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,852,352		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 10:52 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQ FT)	NEW MVBLE EQUIP (EQUIP DEPRN)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	DATA PROCESSING (DEVICES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	77,531					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		386,435				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	8,607,849			4.00
5.01	00540	NONPATIENT TELEPHONES	104	4,093	0	253		5.01
5.02	00550	DATA PROCESSING	203	134,073	0	4	145	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	791	0	0	2	2	5.03
5.04	00570	ADMITTING	504	619	448,253	7	7	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	298	0	3,052	5	1	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	1,474	1,077	1,245,159	14	10	5.06
7.00	00700	OPERATION OF PLANT	21,486	5,460	409,205	22	7	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	132	0	0	0	8.00
9.00	00900	HOUSEKEEPING	392	1,580	225,451	1	2	9.00
10.00	01000	DIETARY	1,369	1,764	112,500	2	2	10.00
11.00	01100	CAFETERIA	3,095	5,293	254,321	5	3	11.00
13.00	01300	NURSING ADMINISTRATION	1,382	205	759,606	4	2	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	875	57	110,681	8	3	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,398	19,263	1,885,204	74	35	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,219	37,087	266,204	6	14	50.00
51.00	05100	RECOVERY ROOM	1,909	4,637	83,908	14	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,705	106,049	774,938	16	14	54.00
56.00	05600	RADIOISOTOPE	0	24,516	38,271	0	0	56.00
60.00	06000	LABORATORY	1,711	3,583	285,915	6	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,610	9,570	242,447	6	8	65.00
66.00	06600	PHYSICAL THERAPY	3,379	23	0	10	6	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,842	0	0	7	0	67.00
68.00	06800	SPEECH PATHOLOGY	384	0	0	2	0	68.00
69.00	06900	ELECTROCARDIOLOGY	419	2,582	320,984	4	2	69.00
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	1,014	774	259,530	6	8	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,554	23,858	882,220	28	19	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)	77,531	386,295	8,607,849	253	145	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	140	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,471,045	381,307	1,417,979	33,377	4,437,059	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.973636	0.986730	0.164731	131.924901	30,600.406897	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	6,012	136,240	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	23.762846	939.586207	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: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 10:52 am

		Cost Center Description	PURCHASING RECEIVING AND STORES (REQUISITIO)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	350,918					5.03
5.04	00570	ADMITTING	5,954	14,505,411				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	91,725,959			5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	26	0	0	-3,694,456	23,399,596	5.06
7.00	00700	OPERATION OF PLANT	101	0	0	0	2,587,869	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	7,985	8.00
9.00	00900	HOUSEKEEPING	26,822	0	0	0	448,391	9.00
10.00	01000	DIETARY	34	0	0	0	298,458	10.00
11.00	01100	CAFETERIA	78	0	0	0	519,539	11.00
13.00	01300	NURSING ADMINISTRATION	9	0	0	0	1,147,594	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	35	0	0	0	332,806	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	85,314	7,092,941	7,094,976	0	4,123,231	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	71,200	365,105	3,805,889	0	1,149,501	50.00
51.00	05100	RECOVERY ROOM	0	3,646	1,151,250	0	210,956	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,940	1,020,268	26,983,299	0	2,490,882	54.00
56.00	05600	RADIOISOTOPE	179	17,191	569,542	0	102,065	56.00
60.00	06000	LABORATORY	99	1,680,432	11,764,068	0	1,199,834	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	17,916	28,454	0	26,151	62.00
65.00	06500	RESPIRATORY THERAPY	15,988	883,074	2,985,530	0	747,606	65.00
66.00	06600	PHYSICAL THERAPY	572	253,270	2,155,771	0	753,445	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	133,535	650,292	0	191,352	67.00
68.00	06800	SPEECH PATHOLOGY	0	16,313	56,357	0	19,994	68.00
69.00	06900	ELECTROCARDIOLOGY	0	207,169	3,904,109	0	650,620	69.00
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	39,991	0	15,775	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,070	2,085,488	7,564,020	0	1,851,745	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	106,497	729,063	22,972,411	0	4,502,762	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)	350,918	14,505,411	91,725,959	-3,694,456	23,378,561	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	138	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	20,897	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	210,256	809,803	648,862		3,694,456	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.599160	0.055828	0.007074		0.157885	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	16,935	17,204	6,713		38,760	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.048259	0.001186	0.000073		0.001656	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: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 10:52 am

		Cost Center Description	OPERATION OF PLANT (SQ FT)	LAUNDRY & LINEN SERVICE (LINEN)	HOUSEKEEPING (NUMBER HOUSED)	DIETARY (DIETARY)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT	52,671					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	63,684				8.00
9.00	00900	HOUSEKEEPING	392	6,165	51,865			9.00
10.00	01000	DIETARY	1,369	551	1,369	7,417		10.00
11.00	01100	CAFETERIA	3,095	1,244	3,095	0	6,737	11.00
13.00	01300	NURSING ADMINISTRATION	1,382	0	1,382	0	689	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	875	0	875	0	211	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,398	21,313	14,398	7,417	1,752	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,219	1,739	3,219	0	488	50.00
51.00	05100	RECOVERY ROOM	1,909	0	1,909	0	9	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,705	6,800	5,705	0	1,047	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	47	56.00
60.00	06000	LABORATORY	1,711	0	1,711	0	462	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,610	462	1,610	0	261	65.00
66.00	06600	PHYSICAL THERAPY	3,379	5,054	3,379	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,842	0	2,842	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	384	0	384	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	419	1,422	419	0	345	69.00
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	1,014	0	1,014	0	304	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,554	18,934	8,554	0	1,122	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)	52,671	63,684	51,865	7,417	6,737	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,996,455	32,798	544,661	438,123	810,784	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	56.890034	0.515012	10.501514	59.070109	120.347929	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	424,446	11,334	17,193	41,723	93,936	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.058438	0.177972	0.331495	5.625320	13.943298	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: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 10:52 am

		Cost Center Description	NURSING ADMINISTRATION (TIME SPENT)	MEDICAL RECORDS & LIBRARY (ASSIGNED TIME)		
			13.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	NONPATIENT TELEPHONES				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00560	PURCHASING RECEIVING AND STORES				5.03
5.04	00570	ADMITTING				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06	00591	ADMINISTRATIVE AND GENERAL				5.06
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	55,192			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	91,725,959		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	31,846	7,094,976		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,805,889		50.00
51.00	05100	RECOVERY ROOM	0	1,151,250		51.00
51.01	05101	O/P TREATMENT ROOM	0	0		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,983,299		54.00
56.00	05600	RADIOISOTOPE	0	569,542		56.00
60.00	06000	LABORATORY	0	11,764,068		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	28,454		62.00
65.00	06500	RESPIRATORY THERAPY	0	2,985,530		65.00
66.00	06600	PHYSICAL THERAPY	0	2,155,771		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	650,292		67.00
68.00	06800	SPEECH PATHOLOGY	0	56,357		68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,904,109		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	39,991		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,564,020		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	23,346	22,972,411		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)	55,192	91,725,959		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	PHYSICIAN PRACTICES	0	0		194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0		194.01
194.02	07952	VPCHC	0	0		194.02
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,504,837	469,712		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.265491	0.005121		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	51,500	30,503		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.933106	0.000333		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: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 10:52 am

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	7,309,111		7,309,111	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,627,039		1,627,039	0	0	50.00
51.00	05100	RECOVERY ROOM	379,892		379,892	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0		0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,536,293		3,536,293	0	0	54.00
56.00	05600	RADIOISOTOPE	126,753		126,753	0	0	56.00
60.00	06000	LABORATORY	1,620,422		1,620,422	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	30,426		30,426	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,021,080	0	1,021,080	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,113,762	0	1,113,762	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	416,420	0	416,420	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	49,319	0	49,319	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	843,825		843,825	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,471		18,471	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,287,764		2,287,764	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	6,689,119		6,689,119	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,925,862		1,925,862		0	92.00
200.00		Subtotal (see instructions)	28,995,558	0	28,995,558	0	0	200.00
201.00		Less Observation Beds	1,925,862		1,925,862		0	201.00
202.00		Total (see instructions)	27,069,696	0	27,069,696	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 10:52 am

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	5,101,782		5,101,782			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	344,302	3,461,587	3,805,889	0.427506	0.000000	50.00
51.00	05100	RECOVERY ROOM	20,803	1,101,599	1,122,402	0.338463	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0.000000	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,020,268	25,963,031	26,983,299	0.131055	0.000000	54.00
56.00	05600	RADIOISOTOPE	17,191	552,351	569,542	0.222553	0.000000	56.00
60.00	06000	LABORATORY	1,680,432	10,083,636	11,764,068	0.137743	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	17,916	10,538	28,454	1.069305	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	883,074	2,102,456	2,985,530	0.342010	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	253,270	1,902,501	2,155,771	0.516642	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	133,535	516,757	650,292	0.640358	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	16,313	40,044	56,357	0.875118	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	207,169	3,696,940	3,904,109	0.216138	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	39,991	39,991	0.461879	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,085,488	5,478,532	7,564,020	0.302453	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	729,063	22,243,348	22,972,411	0.291181	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,925	1,413,199	1,416,124	1.359953	0.000000	92.00
200.00		Subtotal (see instructions)	12,513,531	78,606,510	91,120,041			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,513,531	78,606,510	91,120,041			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 10:52 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
51.01	05101	O/P TREATMENT ROOM	0.000000		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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			
90.00	09000	CLINIC	0.000000		90.00
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: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 10:52 am

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	7,309,111		7,309,111	0	7,309,111	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,627,039		1,627,039	0	1,627,039	50.00
51.00	05100	RECOVERY ROOM	379,892		379,892	0	379,892	51.00
51.01	05101	O/P TREATMENT ROOM	0		0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,536,293		3,536,293	0	3,536,293	54.00
56.00	05600	RADIOISOTOPE	126,753		126,753	0	126,753	56.00
60.00	06000	LABORATORY	1,620,422		1,620,422	0	1,620,422	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	30,426		30,426	0	30,426	62.00
65.00	06500	RESPIRATORY THERAPY	1,021,080	0	1,021,080	0	1,021,080	65.00
66.00	06600	PHYSICAL THERAPY	1,113,762	0	1,113,762	0	1,113,762	66.00
67.00	06700	OCCUPATIONAL THERAPY	416,420	0	416,420	0	416,420	67.00
68.00	06800	SPEECH PATHOLOGY	49,319	0	49,319	0	49,319	68.00
69.00	06900	ELECTROCARDIOLOGY	843,825		843,825	0	843,825	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,471		18,471	0	18,471	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,287,764		2,287,764	0	2,287,764	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	6,689,119		6,689,119	0	6,689,119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,925,862		1,925,862		1,925,862	92.00
200.00		Subtotal (see instructions)	28,995,558	0	28,995,558	0	28,995,558	200.00
201.00		Less Observation Beds	1,925,862		1,925,862		1,925,862	201.00
202.00		Total (see instructions)	27,069,696	0	27,069,696	0	27,069,696	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 10:52 am

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	5,101,782		5,101,782			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	344,302	3,461,587	3,805,889	0.427506	0.000000	50.00
51.00	05100	RECOVERY ROOM	20,803	1,101,599	1,122,402	0.338463	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0.000000	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,020,268	25,963,031	26,983,299	0.131055	0.000000	54.00
56.00	05600	RADIOISOTOPE	17,191	552,351	569,542	0.222553	0.000000	56.00
60.00	06000	LABORATORY	1,680,432	10,083,636	11,764,068	0.137743	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	17,916	10,538	28,454	1.069305	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	883,074	2,102,456	2,985,530	0.342010	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	253,270	1,902,501	2,155,771	0.516642	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	133,535	516,757	650,292	0.640358	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	16,313	40,044	56,357	0.875118	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	207,169	3,696,940	3,904,109	0.216138	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	39,991	39,991	0.461879	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,085,488	5,478,532	7,564,020	0.302453	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	729,063	22,243,348	22,972,411	0.291181	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,925	1,413,199	1,416,124	1.359953	0.000000	92.00
200.00		Subtotal (see instructions)	12,513,531	78,606,510	91,120,041			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,513,531	78,606,510	91,120,041			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 10:52 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
51.01	05101	O/P TREATMENT ROOM	0.000000		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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			
90.00	09000	CLINIC	0.000000		90.00
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: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/26/2022 10:52 am

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	152,406	3,805,889	0.040045	67,982	2,722	50.00
51.00	05100	RECOVERY ROOM	58,091	1,122,402	0.051756	7,125	369	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0.000000	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	308,143	26,983,299	0.011420	138,519	1,582	54.00
56.00	05600	RADIOISOTOPE	25,276	569,542	0.044380	5,278	234	56.00
60.00	06000	LABORATORY	65,700	11,764,068	0.005585	541,512	3,024	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	75	28,454	0.002636	1,470	4	62.00
65.00	06500	RESPIRATORY THERAPY	69,149	2,985,530	0.023161	259,927	6,020	65.00
66.00	06600	PHYSICAL THERAPY	101,710	2,155,771	0.047180	55,577	2,622	66.00
67.00	06700	OCCUPATIONAL THERAPY	78,672	650,292	0.120979	22,207	2,687	67.00
68.00	06800	SPEECH PATHOLOGY	10,630	56,357	0.188619	6,345	1,197	68.00
69.00	06900	ELECTROCARDIOLOGY	23,958	3,904,109	0.006137	96,544	592	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42	39,991	0.001050	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,071	7,564,020	0.006487	660,014	4,282	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	339,722	22,972,411	0.014788	6,034	89	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	150,065	1,416,124	0.105969	0	0	92.00
200.00		Total (lines 50 through 199)	1,432,710	86,018,259		1,868,534	25,424	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/26/2022 10:52 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/26/2022 10:52 am

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	3,805,889	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,122,402	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,983,299	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	569,542	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	11,764,068	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	28,454	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,985,530	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,155,771	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	650,292	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	56,357	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,904,109	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	39,991	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,564,020	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	22,972,411	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,416,124	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	86,018,259		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/26/2022 10:52 am

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	67,982	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	7,125	0	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	138,519	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	5,278	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	541,512	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	1,470	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	259,927	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	55,577	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	22,207	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	6,345	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	96,544	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	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	660,014	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	6,034	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,868,534	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/26/2022 10:52 am

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	0.427506	0	795,543	25,669	0	50.00
51.00	05100	RECOVERY ROOM	0.338463	0	330,272	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131055	0	6,426,270	0	0	54.00
56.00	05600	RADIOISOTOPE	0.222553	0	106,761	0	0	56.00
60.00	06000	LABORATORY	0.137743	0	2,750,587	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.069305	0	7,473	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.342010	0	666,450	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.516642	0	728,153	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.640358	0	131,927	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.875118	0	5,254	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.216138	0	1,150,334	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461879	0	13,810	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302453	0	2,219,854	18,422	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.291181	0	3,989,074	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.359953	0	431,174	0	0	92.00
200.00		Subtotal (see instructions)		0	19,752,936	44,091	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	19,752,936	44,091	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/26/2022 10:52 am

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	340,099	10,974		50.00
51.00	05100	RECOVERY ROOM	111,785	0		51.00
51.01	05101	O/P TREATMENT ROOM	0	0		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	842,195	0		54.00
56.00	05600	RADIOISOTOPE	23,760	0		56.00
60.00	06000	LABORATORY	378,874	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,991	0		62.00
65.00	06500	RESPIRATORY THERAPY	227,933	0		65.00
66.00	06600	PHYSICAL THERAPY	376,194	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	84,481	0		67.00
68.00	06800	SPEECH PATHOLOGY	4,598	0		68.00
69.00	06900	ELECTROCARDIOLOGY	248,631	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,379	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	671,402	5,572		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	1,161,543	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	586,376	0		92.00
200.00		Subtotal (see instructions)	5,072,241	16,546		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,072,241	16,546		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1326 | Component CCN: 15-Z326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V | Date/Time Prepared: 5/26/2022 10:52 am

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	0.427506	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.338463	0	0	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131055	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.222553	0	0	0	0	56.00
60.00	06000	LABORATORY	0.137743	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.069305	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.342010	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.516642	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.640358	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.875118	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.216138	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461879	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302453	0	0	166	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.291181	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.359953	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	166	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	166	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1326 | Component CCN: 15-Z326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V | Date/Time Prepared: 5/26/2022 10:52 am

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
51.00	05100	RECOVERY ROOM	0	0		51.00
51.01	05101	O/P TREATMENT ROOM	0	0		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	50		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	50		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	50		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 10:52 am

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)	3,518	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,866	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)	1,976	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	495	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	157	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)	821	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)	495	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	231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	231.10	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,309,111	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)	36,283	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)	1,107,409	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,201,702	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)	6,201,702	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)	2,163.89	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,776,554	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)	1,776,554	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 10:52 am

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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	486,596	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,263,150	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)	1,071,126	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)	1,071,126	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)	890	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,163.89	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,925,862	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 10:52 am

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	569,534	7,309,111	0.077921	1,925,862	150,065	90.00
91.00	Nursing Program cost	0	7,309,111	0.000000	1,925,862	0	91.00
92.00	Allied health cost	0	7,309,111	0.000000	1,925,862	0	92.00
93.00	All other Medical Education	0	7,309,111	0.000000	1,925,862	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 10:52 am

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)	3,518	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,866	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)	1,976	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	495	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	157	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)	27	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,309,111	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)	1,076,467	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,232,644	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)	6,232,644	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)	2,174.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	58,716	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)	58,716	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 10:52 am

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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	33,505	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	92,221	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)	890	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,174.68	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,935,465	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 10:52 am

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	569,534	7,309,111	0.077921	1,935,465	150,813	90.00
91.00	Nursing Program cost	0	7,309,111	0.000000	1,935,465	0	91.00
92.00	Allied health cost	0	7,309,111	0.000000	1,935,465	0	92.00
93.00	All other Medical Education	0	7,309,111	0.000000	1,935,465	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 10:52 am

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		1,707,840		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.427506	67,982	29,063	50.00
51.00	05100	RECOVERY ROOM	0.338463	7,125	2,412	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131055	138,519	18,154	54.00
56.00	05600	RADIOISOTOPE	0.222553	5,278	1,175	56.00
60.00	06000	LABORATORY	0.137743	541,512	74,589	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.069305	1,470	1,572	62.00
65.00	06500	RESPIRATORY THERAPY	0.342010	259,927	88,898	65.00
66.00	06600	PHYSICAL THERAPY	0.516642	55,577	28,713	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.640358	22,207	14,220	67.00
68.00	06800	SPEECH PATHOLOGY	0.875118	6,345	5,553	68.00
69.00	06900	ELECTROCARDIOLOGY	0.216138	96,544	20,867	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461879	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302453	660,014	199,623	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.291181	6,034	1,757	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.359953	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,868,534	486,596	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,868,534		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1326 | Component CCN: 15-Z326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 10:52 am

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
31.00	03100	INTENSIVE CARE UNIT				31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.427506	1,083	463	50.00
51.00	05100	RECOVERY ROOM	0.338463	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131055	23,796	3,119	54.00
56.00	05600	RADIOISOTOPE	0.222553	0	0	56.00
60.00	06000	LABORATORY	0.137743	63,266	8,714	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.069305	882	943	62.00
65.00	06500	RESPIRATORY THERAPY	0.342010	96,983	33,169	65.00
66.00	06600	PHYSICAL THERAPY	0.516642	110,533	57,106	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.640358	68,290	43,730	67.00
68.00	06800	SPEECH PATHOLOGY	0.875118	4,141	3,624	68.00
69.00	06900	ELECTROCARDIOLOGY	0.216138	3,328	719	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461879	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302453	44,925	13,588	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.291181	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.359953	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		417,227	165,175	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)		417,227		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 10:52 am

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		62,715		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.427506	18,043	7,713	50.00
51.00	05100	RECOVERY ROOM	0.338463	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131055	44,265	5,801	54.00
56.00	05600	RADIOISOTOPE	0.222553	0	0	56.00
60.00	06000	LABORATORY	0.137743	30,398	4,187	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.069305	465	497	62.00
65.00	06500	RESPIRATORY THERAPY	0.342010	10,957	3,747	65.00
66.00	06600	PHYSICAL THERAPY	0.516642	897	463	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.640358	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.875118	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.216138	5,416	1,171	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461879	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302453	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.291181	34,088	9,926	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.359953	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		144,529	33,505	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)		144,529		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1326 | Component CCN: 15-Z326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 10:52 am

Title XIX | 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
31.00	03100	INTENSIVE CARE UNIT				31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.427506	0	0	50.00
51.00	05100	RECOVERY ROOM	0.338463	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131055	0	0	54.00
56.00	05600	RADIOISOTOPE	0.222553	0	0	56.00
60.00	06000	LABORATORY	0.137743	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.069305	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.342010	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.516642	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.640358	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.875118	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.216138	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461879	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302453	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.291181	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.359953	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: 15-1326	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 10:52 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,088,787	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)	5,088,787	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)	5,139,675	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)	79,838	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,221,229	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)	1,838,608	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)	1,838,608	30.00
31.00	Primary payer payments	1,006	31.00
32.00	Subtotal (line 30 minus line 31)	1,837,602	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)	144,662	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	94,030	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,931,632	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)	1,931,632	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	2,979,285	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)	-1,047,653	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: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2022 10:52 am

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		2,059,314		2,979,285	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,059,314		2,979,285	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		83,165		1,047,653	6.02
7.00	Total Medicare program liability (see instructions)		1,976,149		1,931,632	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: 15-1326 | Component CCN: 15-Z326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2022 10:52 am

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		1,142,207		33	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/31/2021	126,400		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)		126,400		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)		1,268,607		33	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		18	6.01
6.02	SETTLEMENT TO PROGRAM		22,716		0	6.02
7.00	Total Medicare program liability (see instructions)		1,245,891		51	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: 15-1326	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/26/2022 10:52 am
	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 (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1326 | Component CCN: 15-Z326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-2 | Date/Time Prepared: 5/26/2022 10:52 am

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)	1,081,837	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)	166,827	51	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	495	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)	1,248,664	51	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,248,664	51	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)	1,248,664	51	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,773	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,245,891	51	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)	1,245,891	51	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	1,268,607	33	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)	-22,716	18	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 - SWING BEDS | Provider CCN: 15-1326 | Component CCN: 15-Z326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-2 | Date/Time Prepared: 5/26/2022 10:52 am

Title XIX | 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)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		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)	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	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)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	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)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0		19.25
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	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)	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		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: 15-1326	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prepared: 5/26/2022 10:52 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,263,150	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)	2,263,150	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,285,782	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)	2,285,782	19.00
20.00	Deductibles (exclude professional component)	310,004	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,975,778	22.00
23.00	Coinsurance	3,339	23.00
24.00	Subtotal (line 22 minus line 23)	1,972,439	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	5,708	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	3,710	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)	1,976,149	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,976,149	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	2,059,314	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)	-83,165	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: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-3 Part VII | Date/Time Prepared: 5/26/2022 10:52 am

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	92,221		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)	92,221	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)	92,221	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	62,715		8.00
9.00	Ancillary service charges	144,529	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)	207,244	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)	207,244	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	115,023	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)	92,221	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)	92,221	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)	92,221	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)	92,221	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	92,221	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)	92,221	0	40.00
41.00	Interim payments	128,256	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-36,035	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: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/26/2022 10:52 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	6,393	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	2,389,899	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	180,448	0	0	0	6.00
7.00	Inventory	373,459	0	0	0	7.00
8.00	Prepaid expenses	58,166,472	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	61,116,671	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	720,525	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	13,966,248	0	0	0	15.00
16.00	Accumulated depreciation	-17,340,818	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	7,970,628	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	5,316,583	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	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	66,433,254	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	794,262	0	0	0	37.00
38.00	Salaries, wages, and fees payable	922,595	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	656,213	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,373,070	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,373,070	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	64,060,184				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	64,060,184	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	66,433,254	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 | Date/Time Prepared: 5/26/2022 10:52 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		52,630,640		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11,429,544				2.00
3.00	Total (sum of line 1 and line 2)		64,060,184		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		64,060,184		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		64,060,184		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2022 10:52 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,440,464		5,440,464	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)	5,440,464		5,440,464	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	5,440,464		5,440,464	17.00
18.00	Ancillary services	6,102,691	56,586,546	62,689,237	18.00
19.00	Outpatient services	729,063	22,261,277	22,990,340	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	PROFESSIONAL FEES	580,716	25,202	605,918	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,852,934	78,873,025	91,725,959	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,684,289		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)		20,684,289		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-3 | Date/Time Prepared: 5/26/2022 10:52 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	91,725,959	1.00
2.00	Less contractual allowances and discounts on patients' accounts	58,433,574	2.00
3.00	Net patient revenues (line 1 minus line 2)	33,292,385	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,684,289	4.00
5.00	Net income from service to patients (line 3 minus line 4)	12,608,096	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	555,478	24.00
24.01	CHANGES IN UHF	4,381	24.01
24.02	INVESTMENT INCOME	845	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	560,704	25.00
26.00	Total (line 5 plus line 25)	13,168,800	26.00
27.00	OTHER EXPENSES	1,739,256	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	1,739,256	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	11,429,544	29.00