

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: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/30/2022 2:39 pm
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 5/30/2022	Time: 2:39 pm
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No.	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 COMMUNITY HOSPITAL OF INDIANA, INC. ( 15-0169 ) 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	Holly Millard	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	Holly Millard		2
3	Signatory Title	SVP FINANCE		3
4	Date	(Dated when report is electronic)		4

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	898,022	-182,181	0	0	1.00
2.00 Subprovider - IPF	0	2,754	9		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
200.00 Total	0	900,776	-182,172	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-0169		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/30/2022 2:39 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 7150 CLEARVISTA DRIVE			PO Box:							1.00	
2.00	City: INDIANAPOLIS			State: IN		Zip Code: 46256		County: MARI ON			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			COMMUNITY HOSPITAL OF INDIANA, INC.	150169	26900	1	02/25/2008	N	P	P	3.00
4.00	Subprovider - IPF			COMMUNITY MENTAL HEALTH	15S169	26900	4	01/01/2010	N	P	O	4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:		To:			
							1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						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.					Y	N				22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y				22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N				22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N			22.03	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N			22.04	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N				23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0169			Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/30/2022 2:39 pm		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	4,631	3,949	0	7	25,798	63	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
						Urban/Rural	S	Date of Geogr	
						1.00		2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	Y	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
<b>Prospective Payment System (PPS)-Capital</b>									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
<b>Teaching Hospitals</b>									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					Y	Y		56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0169		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/30/2022 2:39 pm	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.20
						1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings 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 Nonprovi- der Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
64.00	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. 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: 15-0169

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/30/2022 2:39 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00		
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
				1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010									
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	5.76	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)	FAMILY PRACTICE	1350	0.10	1.20	0.076923	67.00		
							1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.					Y	70.00		
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					N	N	0	71.00
Inpatient Rehabilitation Facility PPS									
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					N	75.00		
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					N	N	0	76.00

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						1.00			
<b>Long Term Care Hospital PPS</b>									
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	
<b>TEFRA Providers</b>									
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		
<b>Title V and XIX Services</b>									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.					N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.					N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						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	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? 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	
<b>Rural Providers</b>									
105.00	Does this hospital qualify as a CAH?					N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					N		108.00	
						Physical	Occupational	Speech	Respiratory
						1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					N	N	N	N
						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: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/30/2022 2:39 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		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:	2,113,788	0	118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0720	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0169		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/30/2022 2:39 pm				
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: COMMUNITY HEALTH NETWORK	Contractor's Name: WISCONSIN PHYSICIANS SERVICES		Contractor's Number: 08101				141.00		
142.00	Street: 1500 NORTH RITTER AVENUE	PO Box:						142.00		
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46219-3095				143.00		
144.00 Are provider based physicians' costs included in Worksheet A?										
Y								144.00		
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		
Y										
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.								146.00		
N										
								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	
								1.00		
								1.00		
								2.00		
								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	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	N	157.00		
158.00	SUBPROVIDER							158.00		
159.00	SNF	N	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	N	160.00		
161.00	CMHC	N	N	N	N	N	N	161.00		
								1.00		
Multi campus										
165.00 Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00	
								1.00		
								5.00		
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	166.00	
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00	
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00	
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01	
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								9.99	169.00	
								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. 1, 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: 15-0169		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part II Date/Time Prepared: 5/30/2022 2:39 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
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				
		1.00	2.00				
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	03/25/2021			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	07/01/2021	Y	07/01/2021		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: 15-0169

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/30/2022 2:39 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N	N	21.00
					1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>						
<b>Capital Related Cost</b>						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
<b>Interest Expense</b>						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
<b>Purchased Services</b>						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
<b>Provider-Based Physicians</b>						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
				Y/N	Date	
				1.00	2.00	
<b>Home Office Costs</b>						
36.00	Were home office costs claimed on the cost report?					36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
				1.00	2.00	
<b>Cost Report Preparer Contact Information</b>						
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.	SHIRLEY		BI SHOP		41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH NETWORK				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-355-4135		SBI SHOP@ECOMMUNITY.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0169

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/30/2022 2:39 pm

		3.00	
<b>Cost Report Preparer Contact Information</b>			
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.	DI RECTOR REIMBURSEMENT	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: 15-0169

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2022 2:39 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				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	238	86,870	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		238	86,870	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	24	8,760	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 NEONATAL INTENSIVE CARE UNIT	35.00	48	17,520	0.00	0	12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		310	113,150	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	18	6,570		0	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)		328				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: 15-0169

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2022 2:39 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	15,502	2,232	62,610			1.00
2.00 HMO and other (see instructions)	15,280	26,832				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	15,502	2,232	62,610			7.00
8.00 INTENSIVE CARE UNIT	1,771	2,067	6,930			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 NEONATAL INTENSIVE CARE UNIT	0	0	13,920			12.00
13.00 NURSERY		3,254	7,863			13.00
14.00 Total (see instructions)	17,273	7,553	91,323	4.20	1,493.80	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,866	0	4,172	2.86	27.51	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)			150			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)				7.06	1,521.31	27.00
28.00 Observation Bed Days		1,625	6,840			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			2,341			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	63	1,700			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: 15-0169

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2022 2:39 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	3,314	406	16,839	1.00
2.00 HMO and other (see instructions)			2,477	3,724		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 NEONATAL INTENSIVE CARE UNIT						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	3,314	406	16,839	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	150	0	377	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 WAGE INDEX INFORMATION

Provider CCN: 15-0169

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/30/2022 2:39 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	119,527,809	-743,979	118,783,830	3,164,320.00	37.54
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		1,288,700	0	1,288,700	4,435.00	290.57
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		279,169	0	279,169	3,533.00	79.02
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		4,023,083	-12,164	4,010,919	109,949.00	36.48
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		10,615,920	0	10,615,920	167,594.00	63.34
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		2,060,411	0	2,060,411	17,067.00	120.72
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		38,535,628	0	38,535,628	796,379.00	48.39
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		29,415,436	0	29,415,436		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,056,172	0	1,056,172		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		53,042	0	53,042		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		42,254	0	42,254		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		9,214,380	0	9,214,380		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0169

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/30/2022 2:39 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)	0	0	0			25.53
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	161,793	0	161,793	3,016.00	53.64	26.00
27.00	Administrative & General	7,011,849	-12,041	6,999,808	184,903.00	37.86	27.00
28.00	Administrative & General under contract (see inst.)	7,338,354	0	7,338,354	59,206.00	123.95	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	1,700,867	-7,133	1,693,734	61,111.00	27.72	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	2,954,485	-28,478	2,926,007	158,444.00	18.47	32.00
33.00	Housekeeping under contract (see instructions)	400,981	0	400,981	8,861.00	45.25	33.00
34.00	Dietary	2,763,474	-1,905,094	858,380	42,380.00	20.25	34.00
35.00	Dietary under contract (see instructions)	483,395	0	483,395	6,240.00	77.47	35.00
36.00	Cafeteria	0	1,893,277	1,893,277	92,205.00	20.53	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	2,446,079	-12,739	2,433,340	62,465.00	38.96	38.00
39.00	Central Services and Supply	883,697	-484	883,213	34,121.00	25.88	39.00
40.00	Pharmacy	5,665,318	-30,870	5,634,448	122,385.00	46.04	40.00
41.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	41.00
42.00	Social Service	1,823,825	-1,158	1,822,667	42,363.00	43.02	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00



HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0169

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/30/2022 2:39 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	127,471,370	-743,979	126,727,391	3,235,094.00	39.17	1.00
2.00	Excluded area salaries (see instructions)	4,023,083	-12,164	4,010,919	109,949.00	36.48	2.00
3.00	Subtotal salaries (line 1 minus line 2)	123,448,287	-731,815	122,716,472	3,125,145.00	39.27	3.00
4.00	Subtotal other wages & related costs (see inst.)	51,211,959	0	51,211,959	981,040.00	52.20	4.00
5.00	Subtotal wage-related costs (see inst.)	38,682,858	0	38,682,858	0.00	31.52	5.00
6.00	Total (sum of lines 3 thru 5)	213,343,104	-731,815	212,611,289	4,106,185.00	51.78	6.00
7.00	Total overhead cost (see instructions)	33,634,117	-104,720	33,529,397	877,700.00	38.20	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2022 2:39 pm
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions		4,704,975	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		15,097	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		253,203	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		11,644,976	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		3,634,218	9.00
10.00	Dental, Hearing and Vision Plan		125,499	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		68,136	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		1,112,321	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		286,812	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		8,615,264	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		106,402	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		30,566,903	24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part V Date/Time Prepared: 5/30/2022 2:39 pm
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Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	10,615,920	30,566,903	1.00
2.00	Hospital	10,615,920	30,566,903	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/30/2022 2:39 pm
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			1.00	
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.219831	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		98,378,746	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		-31,462,293	5.00
6.00	Medicaid charges		403,016,640	6.00
7.00	Medicaid cost (line 1 times line 6)		88,595,551	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)		21,679,098	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)		21,679,098	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)	11,174,645	2,628,160	13,802,805
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,456,533	2,628,160	5,084,693
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	2,456,533	2,628,160	5,084,693
			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)		15,825,049	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		209,179	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		321,814	27.01
28.00	Non-Medicare bad debt expense (see instructions)		15,503,235	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		3,520,727	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		8,605,420	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		30,284,518	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0169

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

Worksheet A  
Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	20,695,915	20,695,915	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	15,094,464	15,094,464	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	161,793	204,432	366,225	-95,180	271,045
5.00	00500	ADMINISTRATIVE & GENERAL	7,011,849	139,790,048	146,801,897	-20,749,864	126,052,033
7.00	00700	OPERATION OF PLANT	1,700,867	7,012,832	8,713,699	-258,516	8,455,183
8.00	00800	LAUNDRY & LINEN SERVICE	0	880,521	880,521	-67	880,454
9.00	00900	HOUSEKEEPING	2,954,485	2,073,300	5,027,785	-24,042	5,003,743
10.00	01000	DIETARY	2,763,474	2,873,336	5,636,810	-3,891,948	1,744,862
11.00	01100	CAFETERIA	0	0	3,796,275	3,796,275	11.00
13.00	01300	NURSING ADMINISTRATION	2,446,079	666,885	3,112,964	-25,087	3,087,877
14.00	01400	CENTRAL SERVICES & SUPPLY	883,697	3,313,931	4,197,628	-2,488,389	1,709,239
15.00	01500	PHARMACY	5,665,318	16,673,171	22,338,489	-14,830,087	7,508,402
16.00	01600	MEDICAL RECORDS & LIBRARY	0	47	47	-47	0
17.00	01700	SOCIAL SERVICE	1,823,825	502,473	2,326,298	-33	2,326,265
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	39,491,417	35,666,627	75,158,044	-13,504,134	61,653,910
31.00	03100	INTENSIVE CARE UNIT	5,334,356	2,995,746	8,330,102	-788,808	7,541,294
35.00	02060	NEONATAL INTENSIVE CARE UNIT	8,753,690	4,780,108	13,533,798	-707,947	12,825,851
40.00	04000	SUBPROVIDER - I PF	2,291,706	618,318	2,910,024	-15,264	2,894,760
43.00	04300	NURSERY	0	0	0	2,821,220	2,821,220
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	4,942,063	35,034,091	39,976,154	-23,152,435	16,823,719
51.00	05100	RECOVERY ROOM	2,967,639	1,513,039	4,480,678	-310,260	4,170,418
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6,460,294	6,460,294
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,703,102	2,608,621	6,311,723	-1,438,727	4,872,996
55.00	05500	RADIOLOGY-THERAPEUTIC	578,748	4,923,948	5,502,696	-3,329,601	2,173,095
57.00	05700	CT SCAN	1,126,459	1,346,101	2,472,560	-132,359	2,340,201
58.00	05800	MRI	628,042	1,943,140	2,571,182	-725,978	1,845,204
59.00	05900	CARDIAC CATHETERIZATION	0	6,344	6,344	-2,723	3,621
60.00	06000	LABORATORY	0	12,525,028	12,525,028	0	12,525,028
64.00	06400	INTRAVENOUS THERAPY	548,130	309,095	857,225	-71,918	785,307
65.00	06500	RESPIRATORY THERAPY	3,532,199	2,781,468	6,313,667	-854,938	5,458,729
66.00	06600	PHYSICAL THERAPY	6,845,871	3,358,862	10,204,733	-3,665,953	6,538,780
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,064,491	2,064,491
68.00	06800	SPEECH PATHOLOGY	0	0	0	420,608	420,608
69.00	06900	ELECTROCARDIOLOGY	39,205	433,012	472,217	18,044	490,261
70.00	07000	ELECTROENCEPHALOGRAPHY	1,120,694	859,532	1,980,226	-252,663	1,727,563
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	17,054,271	17,054,271
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	13,020,384	13,020,384
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,247,271	16,247,271
73.01	07301	SPECIALTY PHARMACY	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	1,262,496	1,262,496	-2,166	1,260,330
76.00	03330	ENDOSCOPY	1,442,225	3,134,245	4,576,470	-1,997,491	2,578,979
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.04	03953	WOUND CARE	436,321	905,192	1,341,513	-200,545	1,140,968
76.06	03954	IMAGING CENTER	1,907,455	2,723,131	4,630,586	-1,295,832	3,334,754
76.07	03955	BREAST DIAGNOSTIC CENTER	0	12,028,066	12,028,066	-410,580	11,617,486
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04950	INFUSION CENTER	116,093	1,837,957	1,954,050	-1,808,938	145,112
90.26	04975	SPINE CENTER	204,600	53,325	257,925	0	257,925
91.00	09100	EMERGENCY	6,375,030	3,903,167	10,278,197	-476,576	9,801,621
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	117,796,432	311,541,635	429,338,067	184,141	429,522,208
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	87,916	87,916	0	87,916
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	194.00
194.06	07956	PAVILLIONS	0	119,373	119,373	-91,529	27,844
194.08	07958	OTHER NRCC	1,731,377	639,066	2,370,443	-92,612	2,277,831

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0169		Period: From 01/01/2021 To 12/31/2021		Worksheet A Date/Time Prepared: 5/30/2022 2:39 pm	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
194.10	07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
200.00	TOTAL (SUM OF LINES 118 through 199)	119,527,809	312,387,990	431,915,799	0	431,915,799	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0169

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

Worksheet A  
Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-6,364,644	14,331,271	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,561,639	17,656,103	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,141,253	6,412,298	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-67,704,288	58,347,745	5.00
7.00	00700	OPERATION OF PLANT	3,003,631	11,458,814	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	880,454	8.00
9.00	00900	HOUSEKEEPING	0	5,003,743	9.00
10.00	01000	DIETARY	-18,744	1,726,118	10.00
11.00	01100	CAFETERIA	-2,171,536	1,624,739	11.00
13.00	01300	NURSING ADMINISTRATION	4,114,100	7,201,977	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,917,247	3,626,486	14.00
15.00	01500	PHARMACY	-98,300	7,410,102	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,472,766	2,472,766	16.00
17.00	01700	SOCIAL SERVICE	0	2,326,265	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	748,193	748,193	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,012,473	1,012,473	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	74,761	61,728,671	30.00
31.00	03100	INTENSIVE CARE UNIT	-7,974	7,533,320	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-433,959	12,391,892	35.00
40.00	04000	SUBPROVIDER - I PF	-63,730	2,831,030	40.00
43.00	04300	NURSERY	0	2,821,220	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-1,394,410	15,429,309	50.00
51.00	05100	RECOVERY ROOM	0	4,170,418	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,460,294	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,573	4,914,569	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,173,095	55.00
57.00	05700	CT SCAN	0	2,340,201	57.00
58.00	05800	MRI	0	1,845,204	58.00
59.00	05900	CARDIAC CATHETERIZATION	179,686	183,307	59.00
60.00	06000	LABORATORY	0	12,525,028	60.00
64.00	06400	INTRAVENOUS THERAPY	0	785,307	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,458,729	65.00
66.00	06600	PHYSICAL THERAPY	-6,060	6,532,720	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,064,491	67.00
68.00	06800	SPEECH PATHOLOGY	0	420,608	68.00
69.00	06900	ELECTROCARDIOLOGY	32,971	523,232	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	364,155	2,091,718	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	17,054,271	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,020,384	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	300,497	16,547,768	73.00
73.01	07301	SPECIALTY PHARMACY	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	1,260,330	74.00
76.00	03330	ENDOSCOPY	0	2,578,979	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.03
76.04	03953	WOUND CARE	0	1,140,968	76.04
76.06	03954	IMAGING CENTER	-51	3,334,703	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	11,617,486	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
90.01	04950	INFUSION CENTER	0	145,112	90.01
90.26	04975	SPINE CENTER	0	257,925	90.26
91.00	09100	EMERGENCY	1,103,924	10,905,545	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-54,194,827	375,327,381	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	87,916	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	HOME OFFICE	0	0	194.00
194.06	07956	PAVILLIONS	0	27,844	194.06
194.08	07958	OTHER NRCC	0	2,277,831	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	-54,194,827	377,720,972	200.00

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6

Date/Time Prepared:  
5/30/2022 2:39 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
<b>A - Chargeable Medical Supplies</b>					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	106,863	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	17,054,271	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
<b>TOTALS</b>			0	17,161,134	
<b>B - Implantable Device Recl ass</b>					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		13,020,384	1.00
2.00					2.00
3.00					3.00
<b>TOTALS</b>			0	13,020,384	
<b>C - Drugs Charges to Pat</b>					
1.00	ELECTROCARDIOLOGY	69.00	0	18,184	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	16,247,271	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
<b>TOTALS</b>			0	16,265,455	
<b>D - Depreciation Expense</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	14,865,959	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00



RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6

Date/Time Prepared:  
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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
TOTALS			0	14,865,959	
E - Interest Expense					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	12,126,391	1.00
TOTALS			0	12,126,391	
F - Other Capital Rental					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,479,515	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
TOTALS			0	8,479,515	
G - STD BENEFIT					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,041	1.00
2.00	OPERATION OF PLANT	7.00	0	7,133	2.00
3.00	HOUSEKEEPING	9.00	0	28,478	3.00
4.00	DIETARY	10.00	0	11,817	4.00
5.00	NURSING ADMINISTRATION	13.00	0	12,739	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	484	6.00
7.00	PHARMACY	15.00	0	30,870	7.00
8.00	SOCIAL SERVICE	17.00	0	1,158	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	244,636	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	28,774	10.00
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	88,801	11.00
12.00	OPERATING ROOM	50.00	0	21,573	12.00
13.00	RECOVERY ROOM	51.00	0	25,344	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	37,489	14.00
15.00	CT SCAN	57.00	0	5,181	15.00
16.00	MRI	58.00	0	10,374	16.00
17.00	INTRAVENOUS THERAPY	64.00	0	8,057	17.00
18.00	RESPIRATORY THERAPY	65.00	0	22,122	18.00
19.00	PHYSICAL THERAPY	66.00	0	53,851	19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,831	20.00
21.00	ENDOSCOPY	76.00	0	10,234	21.00

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6

Date/Time Prepared:  
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Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
22.00	WOUND CARE	76.04	0	3,534	22.00
23.00	IMAGING CENTER	76.06	0	20,719	23.00
24.00	EMERGENCY	91.00	0	43,575	24.00
25.00	OTHER NRCC	194.08	0	12,164	25.00
	<b>TOTALS</b>		<b>0</b>	<b>743,979</b>	
<b>H - Labor and Delivery</b>					
1.00	NURSERY	43.00	1,805,624	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	4,134,688	0	2.00
3.00	NURSERY	43.00	0	1,015,596	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	2,325,606	4.00
	<b>TOTALS</b>		<b>5,940,312</b>	<b>3,341,202</b>	
<b>I - Cafeteria</b>					
1.00	CAFETERIA	11.00	1,893,277	0	1.00
2.00	CAFETERIA	11.00	0	1,902,998	2.00
	<b>TOTALS</b>		<b>1,893,277</b>	<b>1,902,998</b>	
<b>J - Therapy</b>					
1.00	OCCUPATIONAL THERAPY	67.00	1,422,915	0	1.00
2.00	SPEECH PATHOLOGY	68.00	289,897	0	2.00
3.00	OCCUPATIONAL THERAPY	67.00	0	641,576	3.00
4.00	SPEECH PATHOLOGY	68.00	0	130,711	4.00
	<b>TOTALS</b>		<b>1,712,812</b>	<b>772,287</b>	
<b>K - Building Depreciation</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,251,010	1.00
	<b>TOTALS</b>		<b>0</b>	<b>8,251,010</b>	
<b>L - Capital Insurance Costs</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	318,514	1.00
	<b>TOTALS</b>		<b>0</b>	<b>318,514</b>	
<b>M - Radiology Support</b>					
1.00	RADIOLOGY-THERAPEUTIC	55.00	100,745	0	1.00
2.00	CT SCAN	57.00	160,744	0	2.00
3.00	MRI	58.00	57,900	0	3.00
4.00	RADIOLOGY-THERAPEUTIC	55.00	0	109,601	4.00
5.00	CT SCAN	57.00	0	174,876	5.00
6.00	MRI	58.00	0	62,990	6.00
	<b>TOTALS</b>		<b>319,389</b>	<b>347,467</b>	
500.00	<b>Grand Total: Increases</b>		<b>9,865,790</b>	<b>97,596,295</b>	<b>500.00</b>

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6  
Date/Time Prepared:  
5/30/2022 2:39 pm

Decreases							
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
6.00	7.00	8.00	9.00	10.00			
<b>A - Chargeable Medical Supplies</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	664	0	1.00	
2.00	OPERATION OF PLANT	7.00	0	97,163	0	2.00	
3.00	DIETARY	10.00	0	4,142	0	3.00	
4.00	PHARMACY	15.00	0	276,161	0	4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	2,480,430	0	5.00	
6.00	INTENSIVE CARE UNIT	31.00	0	430,889	0	6.00	
7.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	530,786	0	7.00	
8.00	SUBPROVIDER - IPF	40.00	0	2,377	0	8.00	
9.00	OPERATING ROOM	50.00	0	8,707,328	0	9.00	
10.00	RECOVERY ROOM	51.00	0	301,288	0	10.00	
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	295,002	0	11.00	
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	1,434,751	0	12.00	
13.00	CT SCAN	57.00	0	57,638	0	13.00	
14.00	MRI	58.00	0	147,487	0	14.00	
15.00	CARDIAC CATHETERIZATION	59.00	0	1,196	0	15.00	
16.00	INTRAVENOUS THERAPY	64.00	0	67,022	0	16.00	
17.00	RESPIRATORY THERAPY	65.00	0	602,359	0	17.00	
18.00	PHYSICAL THERAPY	66.00	0	8,459	0	18.00	
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	20,947	0	19.00	
20.00	RENAL DIALYSIS	74.00	0	2,166	0	20.00	
21.00	ENDOSCOPY	76.00	0	1,271,617	0	21.00	
22.00	WOUND CARE	76.04	0	46,009	0	22.00	
23.00	IMAGING CENTER	76.06	0	110,663	0	23.00	
24.00	BREAST DIAGNOSTIC CENTER	76.07	0	11,415	0	24.00	
25.00	EMERGENCY	91.00	0	253,175	0	25.00	
	<b>TOTALS</b>		0	17,161,134			
<b>B - Implantable Device Recl ass</b>							
1.00	OPERATING ROOM	50.00	0	11,197,129		1.00	
2.00	RADIOLOGY-THERAPEUTIC	55.00	0	1,509,193		2.00	
3.00	ENDOSCOPY	76.00	0	314,062		3.00	
	<b>TOTALS</b>		0	13,020,384			
<b>C - Drugs Charges to Pat</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	110	0	1.00	
2.00	OPERATION OF PLANT	7.00	0	4,201	0	2.00	
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	8,160	0	3.00	
4.00	PHARMACY	15.00	0	13,672,634	0	4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	67,222	0	5.00	
6.00	INTENSIVE CARE UNIT	31.00	0	16,273	0	6.00	
7.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	1,238	0	7.00	
8.00	SUBPROVIDER - IPF	40.00	0	121	0	8.00	
9.00	OPERATING ROOM	50.00	0	142,466	0	9.00	
10.00	RECOVERY ROOM	51.00	0	2,407	0	10.00	
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	127,051	0	11.00	
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	15,974	0	12.00	
13.00	CT SCAN	57.00	0	181,127	0	13.00	
14.00	MRI	58.00	0	90,621	0	14.00	
15.00	INTRAVENOUS THERAPY	64.00	0	2,040	0	15.00	
16.00	RESPIRATORY THERAPY	65.00	0	2	0	16.00	
17.00	PHYSICAL THERAPY	66.00	0	5,457	0	17.00	
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,653	0	18.00	
19.00	ENDOSCOPY	76.00	0	4,451	0	19.00	
20.00	WOUND CARE	76.04	0	1,957	0	20.00	
21.00	IMAGING CENTER	76.06	0	166,149	0	21.00	
22.00	INFUSION CENTER	90.01	0	1,726,280	0	22.00	
23.00	EMERGENCY	91.00	0	19,423	0	23.00	
24.00	OTHER NRCC	194.08	0	7,438	0	24.00	
	<b>TOTALS</b>		0	16,265,455			
<b>D - Depreciation Expense</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	710	9	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	7,406,864	0	2.00	
3.00	OPERATION OF PLANT	7.00	0	154,523	0	3.00	
4.00	HOUSEKEEPING	9.00	0	5,849	0	4.00	
5.00	DIETARY	10.00	0	91,246	0	5.00	
6.00	NURSING ADMINISTRATION	13.00	0	23,447	0	6.00	
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	84,393	0	7.00	
8.00	PHARMACY	15.00	0	83,058	0	8.00	
9.00	ADULTS & PEDIATRICS	30.00	0	1,656,231	0	9.00	
10.00	INTENSIVE CARE UNIT	31.00	0	340,737	0	10.00	
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	170,668	0	11.00	
12.00	SUBPROVIDER - IPF	40.00	0	12,412	0	12.00	
13.00	OPERATING ROOM	50.00	0	1,521,343	0	13.00	
14.00	RECOVERY ROOM	51.00	0	6,565	0	14.00	
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	349,347	0	15.00	

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6  
Date/Time Prepared:  
5/30/2022 2:39 pm

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	580,029	0	16.00	
17.00	CT SCAN	57.00	0	229,214	0	17.00	
18.00	MRI	58.00	0	608,693	0	18.00	
19.00	CARDIAC CATHETERIZATION	59.00	0	1,527	0	19.00	
20.00	INTRAVENOUS THERAPY	64.00	0	2,856	0	20.00	
21.00	RESPIRATORY THERAPY	65.00	0	58,449	0	21.00	
22.00	PHYSICAL THERAPY	66.00	0	271,226	0	22.00	
23.00	ELECTROCARDIOLOGY	69.00	0	140	0	23.00	
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	47,620	0	24.00	
25.00	ENDOSCOPY	76.00	0	394,963	0	25.00	
26.00	WOUND CARE	76.04	0	43,110	0	26.00	
27.00	IMAGING CENTER	76.06	0	465,414	0	27.00	
28.00	INFUSION CENTER	90.01	0	23,755	0	28.00	
29.00	EMERGENCY	91.00	0	203,978	0	29.00	
30.00	PAVILLIONS	194.06	0	17,484	0	30.00	
31.00	OTHER NRCC	194.08	0	10,108	0	31.00	
	TOTALS		0	14,865,959			
E - Interest Expense							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,126,391	11	1.00	
	TOTALS		0	12,126,391			
F - Other Capital Rental							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	94,470	10	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	897,321	0	2.00	
3.00	OPERATION OF PLANT	7.00	0	2,629	0	3.00	
4.00	LAUNDRY & LINEN SERVICE	8.00	0	67	0	4.00	
5.00	HOUSEKEEPING	9.00	0	18,193	0	5.00	
6.00	DIETARY	10.00	0	285	0	6.00	
7.00	NURSING ADMINISTRATION	13.00	0	1,640	0	7.00	
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,502,699	0	8.00	
9.00	PHARMACY	15.00	0	798,234	0	9.00	
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	47	0	10.00	
11.00	SOCIAL SERVICE	17.00	0	33	0	11.00	
12.00	ADULTS & PEDIATRICS	30.00	0	18,737	0	12.00	
13.00	INTENSIVE CARE UNIT	31.00	0	909	0	13.00	
14.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	5,255	0	14.00	
15.00	SUBPROVIDER - IPF	40.00	0	354	0	15.00	
16.00	OPERATING ROOM	50.00	0	1,584,169	0	16.00	
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	471	0	17.00	
18.00	MRI	58.00	0	67	0	18.00	
19.00	RESPIRATORY THERAPY	65.00	0	194,128	0	19.00	
20.00	PHYSICAL THERAPY	66.00	0	895,712	0	20.00	
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	181,443	0	21.00	
22.00	ENDOSCOPY	76.00	0	12,398	0	22.00	
23.00	WOUND CARE	76.04	0	109,469	0	23.00	
24.00	IMAGING CENTER	76.06	0	553,606	0	24.00	
25.00	BREAST DIAGNOSTIC CENTER	76.07	0	399,165	0	25.00	
26.00	INFUSION CENTER	90.01	0	58,903	0	26.00	
27.00	PAVILLIONS	194.06	0	74,045	0	27.00	
28.00	OTHER NRCC	194.08	0	75,066	0	28.00	
	TOTALS		0	8,479,515			
G - STD BENEFIT							
1.00	ADMINISTRATIVE & GENERAL	5.00	12,041	0	0	1.00	
2.00	OPERATION OF PLANT	7.00	7,133	0	0	2.00	
3.00	HOUSEKEEPING	9.00	28,478	0	0	3.00	
4.00	DIETARY	10.00	11,817	0	0	4.00	
5.00	NURSING ADMINISTRATION	13.00	12,739	0	0	5.00	
6.00	CENTRAL SERVICES & SUPPLY	14.00	484	0	0	6.00	
7.00	PHARMACY	15.00	30,870	0	0	7.00	
8.00	SOCIAL SERVICE	17.00	1,158	0	0	8.00	
9.00	ADULTS & PEDIATRICS	30.00	244,636	0	0	9.00	
10.00	INTENSIVE CARE UNIT	31.00	28,774	0	0	10.00	
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	88,801	0	0	11.00	
12.00	OPERATING ROOM	50.00	21,573	0	0	12.00	
13.00	RECOVERY ROOM	51.00	25,344	0	0	13.00	
14.00	RADIOLOGY-DIAGNOSTIC	54.00	37,489	0	0	14.00	
15.00	CT SCAN	57.00	5,181	0	0	15.00	
16.00	MRI	58.00	10,374	0	0	16.00	
17.00	INTRAVENOUS THERAPY	64.00	8,057	0	0	17.00	
18.00	RESPIRATORY THERAPY	65.00	22,122	0	0	18.00	
19.00	PHYSICAL THERAPY	66.00	53,851	0	0	19.00	
20.00	ELECTROENCEPHALOGRAPHY	70.00	2,831	0	0	20.00	
21.00	ENDOSCOPY	76.00	10,234	0	0	21.00	
22.00	WOUND CARE	76.04	3,534	0	0	22.00	
23.00	IMAGING CENTER	76.06	20,719	0	0	23.00	

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6

Date/Time Prepared:  
5/30/2022 2:39 pm

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
24.00	EMERGENCY	91.00	43,575	0	0		24.00
25.00	OTHER NRCC	194.08	12,164	0	0		25.00
	TOTALS		743,979	0			
<b>H - Labor and Delivery</b>							
1.00	ADULTS & PEDIATRICS	30.00	5,940,312	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	3,341,202	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		5,940,312	3,341,202			
<b>I - Cafeteria</b>							
1.00	DIETARY	10.00	1,893,277				1.00
2.00	DIETARY	10.00		1,902,998			2.00
			1,893,277	1,902,998			
<b>J - Therapy</b>							
1.00	PHYSICAL THERAPY	66.00	1,712,812	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	772,287	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		1,712,812	772,287			
<b>K - Building Depreciation</b>							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,251,010	9		1.00
	TOTALS		0	8,251,010			
<b>L - Capital Insurance Costs</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	318,514	12		1.00
	TOTALS		0	318,514			
<b>M - Radiology Support</b>							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	319,389	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	347,467	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		319,389	347,467			
500.00	Grand Total: Decreases		10,609,769	96,852,316			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0169

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
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		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	2,705,851	0	0	0	0	1.00
2.00	Land Improvements	4,358,832	0	0	0	0	2.00
3.00	Buildings and Fixtures	326,772,560	5,365,629	0	5,365,629	6,080,239	3.00
4.00	Building Improvements	4,611,425	0	0	0	1,086,231	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	123,408,648	-4,648,808	0	-4,648,808	-7,442,299	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	461,857,316	716,821	0	716,821	-275,829	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	461,857,316	716,821	0	716,821	-275,829	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	2,705,851	0				1.00
2.00	Land Improvements	4,358,832	0				2.00
3.00	Buildings and Fixtures	326,057,950	0				3.00
4.00	Building Improvements	3,525,194	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	126,202,139	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	462,849,966	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	462,849,966	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0169

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0169

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	336,647,827	0	336,647,827	0.727337	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	126,202,139	0	126,202,139	0.272663	0	2.00
3.00	Total (sum of lines 1-2)	462,849,966	0	462,849,966	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	8,251,010	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	9,176,588	8,479,515	2.00
3.00	Total (sum of lines 1-2)	0	0	0	17,427,598	8,479,515	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	5,761,747	318,514	0	0	14,331,271	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	17,656,103	2.00
3.00	Total (sum of lines 1-2)	5,761,747	318,514	0	0	31,987,374	3.00



Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,694,992				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	12,876,554				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-2,088,419	CAFETERIA		11.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	UTILIZATION REVIEW-SNF	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0169

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

Worksheet A-8

Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	Ref.	
			Cost Center	Line #			
			1.00	2.00			3.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.00
33.01 Misc Revenue	B	-130,740	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.01
33.02 Misc Revenue	B	-610,941	ADMINISTRATIVE & GENERAL	5.00		0	33.02
33.03 Misc Revenue	B	-18,744	DIETARY	10.00		0	33.03
33.04 Misc Revenue	B	-98,300	PHARMACY	15.00		0	33.04
33.05 Misc Revenue	B	-2,290	NEONATAL INTENSIVE CARE UNIT	35.00		0	33.05
33.06 Misc Revenue	B	-113,321	RADIOLOGY-DIAGNOSTIC	54.00		0	33.06
33.07 Misc Revenue	B	-6,060	PHYSICAL THERAPY	66.00		0	33.07
33.08 Misc Revenue	B	-51	IMAGING CENTER	76.06		0	33.08
33.11 Space Rental Income	B	-4,200	ADMINISTRATIVE & GENERAL	5.00		0	33.11
33.12 Space Rental Income	B	-19,800	OPERATION OF PLANT	7.00		0	33.12
34.00 HAF Tax Offset	A	-31,599,458	ADMINISTRATIVE & GENERAL	5.00		0	34.00
34.01 00 Non-Allow Interest Expense	A	-3,460,872	CAP REL COSTS-BLDG & FIXT	1.00		11	34.01
34.02 LOC Non-Allow Interest Expense	A	-68,090	CAP REL COSTS-BLDG & FIXT	1.00		11	34.02
34.03 12A Non-Allow Interest Expense	A	-84,670	CAP REL COSTS-BLDG & FIXT	1.00		11	34.03
34.04 12B Non-Allow Interest Expense	A	-62,484	CAP REL COSTS-BLDG & FIXT	1.00		11	34.04
34.06 16AB Non-Allow Interest Expense	A	-251,093	CAP REL COSTS-BLDG & FIXT	1.00		11	34.06
34.07 20A Non-Allow Interest Expense	A	-2,437,435	CAP REL COSTS-BLDG & FIXT	1.00		11	34.07
34.08 Non-Allow Debt Issuance Expense	A	-80,713	ADMINISTRATIVE & GENERAL	5.00		0	34.08
34.09 Loss on Assets	A	-47,391	CENTRAL SERVICES & SUPPLY	14.00		0	34.09
34.10 Loss on Assets	A	-21,557	OPERATING ROOM	50.00		0	34.10
35.00 Bad Debt	A	-14,918,457	ADMINISTRATIVE & GENERAL	5.00		0	35.00
35.01 APP	A	-279,169	NEONATAL INTENSIVE CARE UNIT	35.00		0	35.01
35.02 HOSPITALIST LOSS	A	-8,101,674	ADMINISTRATIVE & GENERAL	5.00		0	35.02
36.00 Meals of Wheels Cost	A	-83,117	CAFETERIA	11.00		0	36.00
36.01 SHARED SERVICES	A	179,686	CARDIAC CATHETERIZATION	59.00		0	36.01
36.02 SHARED SERVICES	A	32,971	ELECTROCARDIOLOGY	69.00		0	36.02
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-54,194,827					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: 15-0169  
 Period: From 01/01/2021 To 12/31/2021  
 Worksheet A-8-1  
 Date/Time Prepared: 5/30/2022 2:39 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	21.00	I&R SERVICES-SALARY & FRINGE	RESIDENTS	748,193	0 1.00
2.00	22.00	I&R SERVICES-OTHER PRGM COST	RESIDENTS	1,012,473	0 2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	2,561,639	0 3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	6,271,993	0 3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	58,010,008	69,723,095 3.02
3.03	7.00	OPERATION OF PLANT	HOME OFFICE	3,023,431	0 3.03
3.04	13.00	NURSING ADMINISTRATION	HOME OFFICE	4,114,100	0 3.04
3.05	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	1,964,638	0 3.05
3.06	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	2,472,766	0 3.06
3.07	30.00	ADULTS & PEDIATRICS	HOME OFFICE	163,123	0 3.07
3.08	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	154,894	0 3.08
3.09	70.00	ELECTROENCEPHALOGRAPHY	HOME OFFICE	364,155	0 3.09
3.10	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	300,497	0 3.10
4.00	5.00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR	333,815	0 4.00
4.01	91.00	EMERGENCY	CPN ED ON CALL	1,103,924	0 4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			82,599,649	69,723,095 5.00

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

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

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	B	CHNW	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
  - B. Corporation, partnership, or other organization has financial interest in provider.
  - C. Provider has financial interest in corporation, partnership, or other organization.
  - D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
  - E. Individual is director, officer, administrator, or key person of provider and related organization.
  - F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

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

Provider CCN: 15-0169

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

Worksheet A-8-1

Date/Time Prepared:  
5/30/2022 2:39 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	748,193	0		1.00
2.00	1,012,473	0		2.00
3.00	2,561,639	9		3.00
3.01	6,271,993	0		3.01
3.02	-11,713,087	0		3.02
3.03	3,023,431	0		3.03
3.04	4,114,100	0		3.04
3.05	1,964,638	0		3.05
3.06	2,472,766	0		3.06
3.07	163,123	0		3.07
3.08	154,894	0		3.08
3.09	364,155	0		3.09
3.10	300,497	0		3.10
4.00	333,815	0		4.00
4.01	1,103,924	0		4.01
5.00	12,876,554			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>		

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0169

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

Worksheet A-8-2

Date/Time Prepared:  
5/30/2022 2:39 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	1,009,573	1,009,573	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	88,362	88,362	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	7,974	7,974	0	0	0	3.00
4.00	35.00	AGGREGATE-NEONATAL INTENSIVE CARE UN	152,500	152,500	0	0	0	4.00
5.00	40.00	AGGREGATE-SUBPROVIDER - IPF	63,730	63,730	0	0	0	5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	1,372,853	1,372,853	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			2,694,992	2,694,992	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	35.00	AGGREGATE-NEONATAL INTENSIVE CARE UN	0	0	0	0	0	4.00
5.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	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	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	1,009,573		1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	88,362		2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	7,974		3.00
4.00	35.00	AGGREGATE-NEONATAL INTENSIVE CARE UN	0	0	0	152,500		4.00
5.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	63,730		5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	1,372,853		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,694,992		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	14,331,271	14,331,271			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	17,656,103		17,656,103		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	6,412,298	6,292	94,952	6,513,542	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	58,347,745	415,670	4,071,937	384,359	5.00
7.00 00700	OPERATION OF PLANT	11,458,814	1,823,422	46,852	93,003	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	880,454	53,065	67	0	8.00
9.00 00900	HOUSEKEEPING	5,003,743	132,158	23,984	160,667	9.00
10.00 01000	DIETARY	1,726,118	146,733	21,745	47,134	10.00
11.00 01100	CAFETERIA	1,624,739	319,249	62,363	103,960	11.00
13.00 01300	NURSING ADMINISTRATION	7,201,977	21,924	25,027	133,615	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	3,626,486	334,856	2,627,311	48,497	14.00
15.00 01500	PHARMACY	7,410,102	165,855	872,926	309,388	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,472,766	5,923	47	0	16.00
17.00 01700	SOCIAL SERVICE	2,326,265	39,227	33	100,083	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	748,193	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,012,473	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	61,728,671	4,662,695	823,150	1,828,863	30.00
31.00 03100	INTENSIVE CARE UNIT	7,533,320	899,766	176,983	291,330	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	12,391,892	856,926	160,391	475,789	35.00
40.00 04000	SUBPROVIDER - IPF	2,831,030	157,597	7,978	125,838	40.00
43.00 04300	NURSERY	2,821,220	348,546	44,354	99,147	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	15,429,309	671,236	3,064,442	270,184	50.00
51.00 05100	RECOVERY ROOM	4,170,418	360,319	6,549	161,561	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	6,460,294	798,110	101,568	227,036	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,914,569	229,316	327,162	183,741	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	2,173,095	256,500	404,534	37,311	55.00
57.00 05700	CT SCAN	2,340,201	33,525	230,799	70,396	57.00
58.00 05800	MRI	1,845,204	123,187	497,764	37,095	58.00
59.00 05900	CARDIAC CATHETERIZATION	183,307	0	1,523	0	59.00
60.00 06000	LABORATORY	12,525,028	131,298	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	785,307	184,854	2,849	29,655	64.00
65.00 06500	RESPIRATORY THERAPY	5,458,729	142,014	251,971	192,738	65.00
66.00 06600	PHYSICAL THERAPY	6,532,720	22,858	1,095,065	278,899	66.00
67.00 06700	OCCUPATIONAL THERAPY	2,064,491	0	57,382	78,132	67.00
68.00 06800	SPEECH PATHOLOGY	420,608	0	11,691	15,918	68.00
69.00 06900	ELECTROCARDIOLOGY	523,232	0	0	2,153	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	2,091,718	78,061	228,513	61,382	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,054,271	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	13,020,384	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	16,547,768	0	0	0	73.00
73.01 07301	SPECIALTY PHARMACY	0	0	0	0	73.01
74.00 07400	RENAL DIALYSIS	1,260,330	2,556	0	0	74.00
76.00 03330	ENDOSCOPY	2,578,979	183,183	385,086	78,631	76.00
76.01 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.01
76.02 03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.02
76.03 03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.03
76.04 03953	WOUND CARE	1,140,968	0	152,213	23,764	76.04
76.06 03954	IMAGING CENTER	3,334,703	0	948,323	103,601	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	11,617,486	0	398,207	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	INFUSION CENTER	145,112	0	82,461	6,375	90.01
90.26 04975	SPINE CENTER	257,925	0	0	11,235	90.26
91.00 09100	EMERGENCY	10,905,545	624,513	171,621	347,660	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	375,327,381	14,231,434	17,479,823	6,419,140	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	86,368	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	87,916	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
194.06 07956 PAVILLIONS	27,844	0	91,309	0	119,153	194.06
194.08 07958 OTHER NRCC	2,277,831	13,469	84,971	94,402	2,470,673	194.08
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
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)	377,720,972	14,331,271	17,656,103	6,513,542	377,720,972	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/30/2022 2:39 pm		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	63,219,711				5.00
7.00	00700	OPERATION OF PLANT	2,698,055	16,120,146			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	187,666	70,778	1,192,030		8.00
9.00	00900	HOUSEKEEPING	1,069,516	176,272	0	6,566,340	9.00
10.00	01000	DIETARY	390,319	195,712	0	80,962	2,608,723
11.00	01100	CAFETERIA	424,206	425,814	0	176,150	0
13.00	01300	NURSING ADMINISTRATION	1,484,009	29,242	0	12,097	0
14.00	01400	CENTRAL SERVICES & SUPPLY	1,334,173	446,631	0	184,761	0
15.00	01500	PHARMACY	1,760,553	221,217	0	91,513	0
16.00	01600	MEDICAL RECORDS & LIBRARY	498,266	7,901	0	3,268	0
17.00	01700	SOCIAL SERVICE	495,627	52,321	0	21,644	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	150,399	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	203,523	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	13,878,748	6,219,098	617,978	2,572,698	2,209,887
31.00	03100	INTENSIVE CARE UNIT	1,789,324	1,200,107	55,183	496,457	248,645
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,791,107	1,142,967	61,752	472,820	0
40.00	04000	SUBPROVIDER - I PF	627,661	210,202	5,691	86,956	150,191
43.00	04300	NURSERY	666,020	464,891	31,556	192,315	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,906,780	895,294	61,421	370,363	0
51.00	05100	RECOVERY ROOM	944,543	480,594	0	198,811	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,525,110	1,064,518	72,261	440,367	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,136,703	305,862	87,035	126,528	0
55.00	05500	RADIOLOGY-THERAPEUTIC	577,205	342,120	15,808	141,527	0
57.00	05700	CT SCAN	537,702	44,716	0	18,498	0
58.00	05800	MRI	503,193	164,307	0	67,970	0
59.00	05900	CARDIAC CATHETERIZATION	37,154	0	0	0	0
60.00	06000	LABORATORY	2,544,124	175,125	0	72,445	0
64.00	06400	INTRAVENOUS THERAPY	201,552	246,558	0	101,996	0
65.00	06500	RESPIRATORY THERAPY	1,215,233	189,418	0	78,358	0
66.00	06600	PHYSICAL THERAPY	1,593,965	30,488	0	12,612	0
67.00	06700	OCCUPATIONAL THERAPY	442,236	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	90,099	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	105,611	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	494,434	104,118	0	43,071	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,428,181	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,617,306	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,326,366	0	0	0	0
73.01	07301	SPECIALTY PHARMACY	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	253,860	3,409	0	1,410	0
76.00	03330	ENDOSCOPY	648,453	244,329	30,422	101,073	0
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.04	03953	WOUND CARE	264,727	0	0	0	0
76.06	03954	IMAGING CENTER	881,782	0	0	0	0
76.07	03955	BREAST DIAGNOSTIC CENTER	2,415,347	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
90.01	04950	INFUSION CENTER	47,027	0	0	0	0
90.26	04975	SPINE CENTER	54,105	0	0	0	0
91.00	09100	EMERGENCY	2,422,110	832,974	152,923	344,583	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,664,080	15,986,983	1,192,030	6,511,253	2,608,723
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,361	115,198	0	47,655	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,673	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	HOME OFFICE	0	0	0	0	0
194.06	07956	PAVILLIONS	23,952	0	0	0	0
194.08	07958	OTHER NRCC	496,645	17,965	0	7,432	0
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0



COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0169			Period: From 01/01/2021 To 12/31/2021		Worksheet B Part I Date/Time Prepared: 5/30/2022 2:39 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
202.00	TOTAL (sum lines 118 through 201)	63,219,711	16,120,146	1,192,030	6,566,340	2,608,723	202.00	

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0169		Period: From 01/01/2021 To 12/31/2021		Worksheet B Part I Date/Time Prepared: 5/30/2022 2:39 pm	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	3,136,481					11.00
13.00	01300	NURSING ADMINISTRATION	80,560	8,988,451				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	42,965	0	8,645,680			14.00
15.00	01500	PHARMACY	158,435	0	0	10,989,989		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	2,988,171	16.00
17.00	01700	SOCIAL SERVICE	53,707	0	77	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,111,732	4,499,659	538,881	0	414,965	30.00
31.00	03100	INTENSIVE CARE UNIT	177,233	717,337	93,635	0	57,246	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	265,849	1,076,006	156,522	0	211,635	35.00
40.00	04000	SUBPROVIDER - I PF	75,190	304,325	12,834	0	17,765	40.00
43.00	04300	NURSERY	59,078	239,112	29,174	0	19,689	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	171,862	695,600	1,274,602	0	426,776	50.00
51.00	05100	RECOVERY ROOM	91,302	0	48,968	0	72,504	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	136,953	554,306	66,806	0	45,085	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	102,043	0	34,372	0	73,653	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	18,797	0	58,386	0	75,618	55.00
57.00	05700	CT SCAN	37,595	0	34,511	0	141,865	57.00
58.00	05800	MRI	21,483	0	7,190	0	51,157	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	633	0	7,990	59.00
60.00	06000	LABORATORY	0	0	364,759	0	239,043	60.00
64.00	06400	INTRAVENOUS THERAPY	13,427	0	3,945	0	2,319	64.00
65.00	06500	RESPIRATORY THERAPY	99,358	0	100,938	0	64,659	65.00
66.00	06600	PHYSICAL THERAPY	37,595	0	26,741	0	44,185	66.00
67.00	06700	OCCUPATIONAL THERAPY	42,965	0	6,229	0	13,184	67.00
68.00	06800	SPEECH PATHOLOGY	8,056	0	1,269	0	4,068	68.00
69.00	06900	ELECTROCARDIOLOGY	2,685	0	196	0	16,918	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	34,909	0	26,951	0	26,048	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	3,078,843	0	115,353	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,350,609	0	77,901	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,989,989	213,391	73.00
73.01	07301	SPECIALTY PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	3,898	0	10,703	74.00
76.00	03330	ENDOSCOPY	48,336	0	73,898	0	53,054	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04	03953	WOUND CARE	16,112	0	25,062	0	8,303	76.04
76.06	03954	IMAGING CENTER	0	0	28,036	0	102,568	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	1,917	0	52,617	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	INFUSION CENTER	5,371	0	242	0	5,828	90.01
90.26	04975	SPINE CENTER	0	0	715	0	858	90.26
91.00	09100	EMERGENCY	222,883	902,106	188,875	0	321,223	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,136,481	8,988,451	8,639,714	10,989,989	2,988,171	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,375	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	PAVILLIONS	0	0	1,870	0	0	194.06
194.08	07958	OTHER NRCC	0	0	2,721	0	0	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	3,136,481	8,988,451	8,645,680	10,989,989	2,988,171	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		Subtotal	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
			17.00	19.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE	3,088,984				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0		898,592		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0			1,215,996	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	2,024,954	0	406,178	549,650	104,087,807 30.00
31.00 03100	INTENSIVE CARE UNIT	224,132	0	0	0	13,960,698 31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	450,205	0	0	0	20,513,861 35.00
40.00 04000	SUBPROVIDER - I/PF	135,385	0	414,957	561,529	5,725,129 40.00
43.00 04300	NURSERY	254,308	0	0	0	5,269,410 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	8,057	10,903	27,256,829 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	6,535,569 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	11,492,414 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	7,520,984 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	4,100,901 55.00
57.00 05700	CT SCAN	0	0	0	0	3,489,808 57.00
58.00 05800	MRI	0	0	0	0	3,318,550 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	230,607 59.00
60.00 06000	LABORATORY	0	0	0	0	16,051,822 60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	1,572,462 64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	7,793,416 65.00
66.00 06600	PHYSICAL THERAPY	0	0	30,525	41,307	9,746,960 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	2,704,619 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	551,709 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	650,795 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	3,189,205 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	23,676,648 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	18,066,200 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	31,077,514 73.00
73.01 07301	SPECIALTY PHARMACY	0	0	0	0	0 73.01
74.00 07400	RENAL DIALYSIS	0	0	0	0	1,536,166 74.00
76.00 03330	ENDOSCOPY	0	0	0	0	4,425,444 76.00
76.01 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.01
76.02 03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.02
76.03 03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.03
76.04 03953	WOUND CARE	0	0	0	0	1,631,149 76.04
76.06 03954	IMAGING CENTER	0	0	0	0	5,399,013 76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	0	0	0	14,485,574 76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0 90.00
90.01 04950	INFUSION CENTER	0	0	0	0	292,416 90.01
90.26 04975	SPINE CENTER	0	0	0	0	324,838 90.26
91.00 09100	EMERGENCY	0	0	38,875	52,607	17,528,498 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
114.00 11400	UTILIZATION REVIEW-SNF					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	3,088,984	0	898,592	1,215,996	374,207,015 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	266,582 190.00
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	106,964 192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00 07950	HOME OFFICE	0	0	0	0	0 194.00
194.06 07956	PAVILLIONS	0	0	0	0	144,975 194.06
194.08 07958	OTHER NRCC	0	0	0	0	2,995,436 194.08

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

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Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		Subtotal	
					SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
					17.00	19.00		
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,088,984	0	898,592	1,215,996	377,720,972	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	-955,828	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	35.00
40.00	04000	SUBPROVIDER - I PF	-976,486	40.00
43.00	04300	NURSERY	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	-18,960	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	-71,832	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
73.01	07301	SPECIALTY PHARMACY	0	73.01
74.00	07400	RENAL DIALYSIS	0	74.00
76.00	03330	ENDOSCOPY	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	76.03
76.04	03953	WOUND CARE	0	76.04
76.06	03954	IMAGING CENTER	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0	90.00
90.01	04950	INFUSION CENTER	0	90.01
90.26	04975	SPINE CENTER	0	90.26
91.00	09100	EMERGENCY	-91,482	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,114,588	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	19100	RESEARCH	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07950	HOME OFFICE	0	194.00
194.06	07956	PAVILLIONS	0	194.06
194.08	07958	OTHER NRCC	0	194.08

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	194.10
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	-2,114,588	375,606,384	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/30/2022 2: 39 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,292	94,952	101,244	101,244 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	415,670	4,071,937	4,487,607	5,978 5.00
7.00 00700	OPERATION OF PLANT	0	1,823,422	46,852	1,870,274	1,446 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	53,065	67	53,132	0 8.00
9.00 00900	HOUSEKEEPING	0	132,158	23,984	156,142	2,499 9.00
10.00 01000	DIETARY	0	146,733	21,745	168,478	733 10.00
11.00 01100	CAFETERIA	0	319,249	62,363	381,612	1,617 11.00
13.00 01300	NURSING ADMINISTRATION	0	21,924	25,027	46,951	2,078 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	334,856	2,627,311	2,962,167	754 14.00
15.00 01500	PHARMACY	0	165,855	872,926	1,038,781	4,812 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	5,923	47	5,970	0 16.00
17.00 01700	SOCIAL SERVICE	0	39,227	33	39,260	1,557 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	4,662,695	823,150	5,485,845	28,383 30.00
31.00 03100	INTENSIVE CARE UNIT	0	899,766	176,983	1,076,749	4,531 31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	856,926	160,391	1,017,317	7,400 35.00
40.00 04000	SUBPROVIDER - I PF	0	157,597	7,978	165,575	1,957 40.00
43.00 04300	NURSERY	0	348,546	44,354	392,900	1,542 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	671,236	3,064,442	3,735,678	4,202 50.00
51.00 05100	RECOVERY ROOM	0	360,319	6,549	366,868	2,513 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	798,110	101,568	899,678	3,531 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	229,316	327,162	556,478	2,858 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	256,500	404,534	661,034	580 55.00
57.00 05700	CT SCAN	0	33,525	230,799	264,324	1,095 57.00
58.00 05800	MRI	0	123,187	497,764	620,951	577 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	1,523	1,523	0 59.00
60.00 06000	LABORATORY	0	131,298	0	131,298	0 60.00
64.00 06400	INTRAVENOUS THERAPY	0	184,854	2,849	187,703	461 64.00
65.00 06500	RESPIRATORY THERAPY	0	142,014	251,971	393,985	2,998 65.00
66.00 06600	PHYSICAL THERAPY	0	22,858	1,095,065	1,117,923	4,338 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	57,382	57,382	1,215 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	11,691	11,691	248 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	33 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	78,061	228,513	306,574	955 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
73.01 07301	SPECIALTY PHARMACY	0	0	0	0	0 73.01
74.00 07400	RENAL DIALYSIS	0	2,556	0	2,556	0 74.00
76.00 03330	ENDOSCOPY	0	183,183	385,086	568,269	1,223 76.00
76.01 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.01
76.02 03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.02
76.03 03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.03
76.04 03953	WOUND CARE	0	0	152,213	152,213	370 76.04
76.06 03954	IMAGING CENTER	0	0	948,323	948,323	1,611 76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	0	398,207	398,207	0 76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0 90.00
90.01 04950	INFUSION CENTER	0	0	82,461	82,461	99 90.01
90.26 04975	SPINE CENTER	0	0	0	0	175 90.26
91.00 09100	EMERGENCY	0	624,513	171,621	796,134	5,407 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	0 114.00
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	0	14,231,434	17,479,823	31,711,257	99,776 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	86,368	0	86,368	0 190.00
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00 07950	HOME OFFICE	0	0	0	0	0 194.00
194.06 07956	PAVILLIONS	0	0	91,309	91,309	0 194.06



ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
	0			2A	4.00	
194.08 07958 OTHER NRCC	0	13,469	84,971	98,440	1,468	194.08
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
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	14,331,271	17,656,103	31,987,374	101,244	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/30/2022 2:39 pm			
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	4,493,585			5.00	
7.00	00700	OPERATION OF PLANT	191,775	2,063,495		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	13,339	9,060	75,531	8.00	
9.00	00900	HOUSEKEEPING	76,020	22,564	0	9.00	
10.00	01000	DIETARY	27,743	25,053	0	10.00	
11.00	01100	CAFETERIA	30,152	54,507	0	11.00	
13.00	01300	NURSING ADMINISTRATION	105,482	3,743	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	94,832	57,172	0	14.00	
15.00	01500	PHARMACY	125,138	28,317	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	35,416	1,011	0	16.00	
17.00	01700	SOCIAL SERVICE	35,229	6,697	0	17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	10,690	0	0	21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	14,466	0	0	22.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	986,484	796,092	39,155	30.00	
31.00	03100	INTENSIVE CARE UNIT	127,183	153,622	3,497	31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	198,389	146,308	3,913	35.00	
40.00	04000	SUBPROVIDER - I PF	44,613	26,907	361	40.00	
43.00	04300	NURSERY	47,340	59,509	1,999	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	277,690	114,604	3,892	50.00	
51.00	05100	RECOVERY ROOM	67,137	61,519	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	108,403	136,266	4,579	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	80,796	39,153	5,515	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	41,027	43,794	1,002	55.00	
57.00	05700	CT SCAN	38,219	5,724	0	57.00	
58.00	05800	MRI	35,766	21,032	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	2,641	0	0	59.00	
60.00	06000	LABORATORY	180,834	22,417	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	14,326	31,561	0	64.00	
65.00	06500	RESPIRATORY THERAPY	86,377	24,247	0	65.00	
66.00	06600	PHYSICAL THERAPY	113,297	3,903	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	31,434	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	6,404	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	7,507	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	35,144	13,328	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	243,671	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	186,035	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	236,435	0	0	73.00	
73.01	07301	SPECIALTY PHARMACY	0	0	0	73.01	
74.00	07400	RENAL DIALYSIS	18,044	436	0	74.00	
76.00	03330	ENDOSCOPY	46,091	31,276	1,928	76.00	
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.01	
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.02	
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.03	
76.04	03953	WOUND CARE	18,817	0	0	76.04	
76.06	03954	IMAGING CENTER	62,676	0	0	76.06	
76.07	03955	BREAST DIAGNOSTIC CENTER	171,680	0	0	76.07	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	90.00	
90.01	04950	INFUSION CENTER	3,343	0	0	90.01	
90.26	04975	SPINE CENTER	3,846	0	0	90.26	
91.00	09100	EMERGENCY	172,161	106,627	9,690	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE				113.00	
114.00	11400	UTILIZATION REVIEW-SNF				114.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,454,092	2,046,449	75,531	255,067	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,234	14,746	0	190.00	
191.00	19100	RESEARCH	0	0	0	191.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,256	0	0	192.00	
193.00	19300	NONPAID WORKERS	0	0	0	193.00	
194.00	07950	HOME OFFICE	0	0	0	194.00	
194.06	07956	PAVILLIONS	1,702	0	0	194.06	
194.08	07958	OTHER NRCC	35,301	2,300	0	194.08	
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	194.10	
200.00		Cross Foot Adjustments				200.00	
201.00		Negative Cost Centers	0	0	0	201.00	

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0169			Period: From 01/01/2021 To 12/31/2021		Worksheet B Part II Date/Time Prepared: 5/30/2022 2:39 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
202.00	TOTAL (sum lines 118 through 201)	4,493,585	2,063,495	75,531	257,225	225,179	202.00	

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0169		Period: From 01/01/2021 To 12/31/2021		Worksheet B Part II Date/Time Prepared: 5/30/2022 2:39 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	474,788					11.00
13.00	01300	12,195	170,923				13.00
14.00	01400	6,504	0	3,128,667			14.00
15.00	01500	23,983	0	0	1,224,616		15.00
16.00	01600	0	0	0	0	42,525	16.00
17.00	01700	8,130	0	28	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	168,292	85,565	195,009	0	5,878	30.00
31.00	03100	26,829	13,641	33,885	0	811	31.00
35.00	02060	40,243	20,461	56,642	0	2,998	35.00
40.00	04000	11,382	5,787	4,644	0	252	40.00
43.00	04300	8,943	4,547	10,558	0	279	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	26,016	13,227	461,251	0	6,241	50.00
51.00	05100	13,821	0	17,720	0	1,027	51.00
52.00	05200	20,731	10,541	24,176	0	639	52.00
54.00	05400	15,447	0	12,439	0	1,043	54.00
55.00	05500	2,845	0	21,129	0	1,071	55.00
57.00	05700	5,691	0	12,489	0	2,009	57.00
58.00	05800	3,252	0	2,602	0	725	58.00
59.00	05900	0	0	229	0	113	59.00
60.00	06000	0	0	131,998	0	3,386	60.00
64.00	06400	2,032	0	1,428	0	33	64.00
65.00	06500	15,040	0	36,527	0	916	65.00
66.00	06600	5,691	0	9,677	0	626	66.00
67.00	06700	6,504	0	2,254	0	187	67.00
68.00	06800	1,219	0	459	0	58	68.00
69.00	06900	406	0	71	0	240	69.00
70.00	07000	5,284	0	9,753	0	369	70.00
71.00	07100	0	0	1,114,144	0	1,634	71.00
72.00	07200	0	0	850,635	0	1,103	72.00
73.00	07300	0	0	0	1,224,616	3,023	73.00
73.01	07301	0	0	0	0	0	73.01
74.00	07400	0	0	1,411	0	152	74.00
76.00	03330	7,317	0	26,742	0	751	76.00
76.01	03950	0	0	0	0	0	76.01
76.02	03951	0	0	0	0	0	76.02
76.03	03952	0	0	0	0	0	76.03
76.04	03953	2,439	0	9,070	0	118	76.04
76.06	03954	0	0	10,146	0	1,453	76.06
76.07	03955	0	0	694	0	745	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.01	04950	813	0	88	0	83	90.01
90.26	04975	0	0	259	0	12	90.26
91.00	09100	33,739	17,154	68,350	0	4,550	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
114.00	11400						114.00
118.00		474,788	170,923	3,126,507	1,224,616	42,525	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	498	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.06	07956	0	0	677	0	0	194.06
194.08	07958	0	0	985	0	0	194.08
194.10	07960	0	0	0	0	0	194.10
200.00							200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0169			Period: From 01/01/2021 To 12/31/2021		Worksheet B Part II Date/Time Prepared: 5/30/2022 2:39 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	474,788	170,923	3,128,667	1,224,616	42,525	202.00	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/30/2022 2:39 pm
Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		Subtotal
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
			17.00	19.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE	91,749			17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0		10,690	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		14,466	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 03000	ADULTS & PEDIATRICS	60,146			8,142,381 30.00
31.00 03100	INTENSIVE CARE UNIT	6,657			1,488,315 31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	13,372			1,525,565 35.00
40.00 04000	SUBPROVIDER - I PF	4,021			281,869 40.00
43.00 04300	NURSERY	7,553			542,704 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000	OPERATING ROOM	0			4,657,309 50.00
51.00 05100	RECOVERY ROOM	0			538,393 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0			1,225,795 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0			718,686 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0			778,026 55.00
57.00 05700	CT SCAN	0			330,276 57.00
58.00 05800	MRI	0			687,568 58.00
59.00 05900	CARDIAC CATHETERIZATION	0			4,506 59.00
60.00 06000	LABORATORY	0			472,771 60.00
64.00 06400	INTRAVENOUS THERAPY	0			241,540 64.00
65.00 06500	RESPIRATORY THERAPY	0			563,160 65.00
66.00 06600	PHYSICAL THERAPY	0			1,255,949 66.00
67.00 06700	OCCUPATIONAL THERAPY	0			98,976 67.00
68.00 06800	SPEECH PATHOLOGY	0			20,079 68.00
69.00 06900	ELECTROCARDIOLOGY	0			8,257 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0			373,094 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0			1,359,449 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0			1,037,773 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0			1,464,074 73.00
73.01 07301	SPECIALTY PHARMACY	0			0 73.01
74.00 07400	RENAL DIALYSIS	0			22,654 74.00
76.00 03330	ENDOSCOPY	0			687,556 76.00
76.01 03950	OTHER ANCILLARY SERVICE COST CENTERS	0			0 76.01
76.02 03951	OTHER ANCILLARY SERVICE COST CENTERS	0			0 76.02
76.03 03952	OTHER ANCILLARY SERVICE COST CENTERS	0			0 76.03
76.04 03953	WOUND CARE	0			183,027 76.04
76.06 03954	IMAGING CENTER	0			1,024,209 76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0			571,326 76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000	CLINIC	0			0 90.00
90.01 04950	INFUSION CENTER	0			86,887 90.01
90.26 04975	SPINE CENTER	0			4,292 90.26
91.00 09100	EMERGENCY	0			1,227,310 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00 11300	INTEREST EXPENSE				113.00
114.00 11400	UTILIZATION REVIEW-SNF				114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	91,749	0	0	31,623,776 118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			104,215 190.00
191.00 19100	RESEARCH	0			0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0			1,754 192.00
193.00 19300	NONPAID WORKERS	0			0 193.00
194.00 07950	HOME OFFICE	0			0 194.00
194.06 07956	PAVILLIONS	0			93,688 194.06
194.08 07958	OTHER NRCC	0			138,785 194.08

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		Subtotal	
					SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
					17.00	19.00		
194.10	07960	COMMUNITY REHAB HOSPITAL	0				0	194.10
200.00		Cross Foot Adjustments		0	10,690	14,466	25,156	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	91,749	0	10,690	14,466	31,987,374	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/30/2022 2:39 pm
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	8,142,381	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,488,315	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	1,525,565	35.00
40.00	04000	SUBPROVIDER - I PF	0	281,869	40.00
43.00	04300	NURSERY	0	542,704	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	4,657,309	50.00
51.00	05100	RECOVERY ROOM	0	538,393	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,225,795	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	718,686	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	778,026	55.00
57.00	05700	CT SCAN	0	330,276	57.00
58.00	05800	MRI	0	687,568	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,506	59.00
60.00	06000	LABORATORY	0	472,771	60.00
64.00	06400	INTRAVENOUS THERAPY	0	241,540	64.00
65.00	06500	RESPIRATORY THERAPY	0	563,160	65.00
66.00	06600	PHYSICAL THERAPY	0	1,255,949	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	98,976	67.00
68.00	06800	SPEECH PATHOLOGY	0	20,079	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,257	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	373,094	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,359,449	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,037,773	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,464,074	73.00
73.01	07301	SPECIALTY PHARMACY	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	22,654	74.00
76.00	03330	ENDOSCOPY	0	687,556	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.03
76.04	03953	WOUND CARE	0	183,027	76.04
76.06	03954	IMAGING CENTER	0	1,024,209	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	571,326	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
90.01	04950	INFUSION CENTER	0	86,887	90.01
90.26	04975	SPINE CENTER	0	4,292	90.26
91.00	09100	EMERGENCY	0	1,227,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	31,623,776	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	104,215	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,754	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	HOME OFFICE	0	0	194.00
194.06	07956	PAVILLIONS	0	93,688	194.06
194.08	07958	OTHER NRCC	0	138,785	194.08



ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0169		Period: From 01/01/2021 To 12/31/2021		Worksheet B Part II Date/Time Prepared: 5/30/2022 2:39 pm	
Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total				
194.10	07960	COMMUNITY REHAB HOSPITAL	25.00	26.00				
200.00		Cross Foot Adjustments	0	0				194.10
201.00		Negative Cost Centers	0	25,156				200.00
202.00		TOTAL (sum lines 118 through 201)	0	31,987,374				201.00
								202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1

Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	583,084				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		17,698,576			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	256	95,180	118,622,037		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	16,912	4,081,732	6,999,808	-63,219,711	5.00
7.00 00700	OPERATION OF PLANT	74,188	46,965	1,693,734	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,159	67	0	0	8.00
9.00 00900	HOUSEKEEPING	5,377	24,042	2,926,007	0	9.00
10.00 01000	DIETARY	5,970	21,797	858,380	0	10.00
11.00 01100	CAFETERIA	12,989	62,513	1,893,277	0	11.00
13.00 01300	NURSING ADMINISTRATION	892	25,087	2,433,340	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	13,624	2,633,632	883,213	0	14.00
15.00 01500	PHARMACY	6,748	875,026	5,634,448	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	241	47	0	0	16.00
17.00 01700	SOCIAL SERVICE	1,596	33	1,822,667	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	189,707	825,130	33,306,469	0	30.00
31.00 03100	INTENSIVE CARE UNIT	36,608	177,409	5,305,582	0	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	34,865	160,777	8,664,889	0	35.00
40.00 04000	SUBPROVIDER - IPF	6,412	7,997	2,291,706	0	40.00
43.00 04300	NURSERY	14,181	44,461	1,805,624	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	27,310	3,071,814	4,920,490	0	50.00
51.00 05100	RECOVERY ROOM	14,660	6,565	2,942,295	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	32,472	101,812	4,134,688	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	9,330	327,949	3,346,224	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	10,436	405,507	679,493	0	55.00
57.00 05700	CT SCAN	1,364	231,354	1,282,022	0	57.00
58.00 05800	MRI	5,012	498,962	675,568	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	1,527	0	0	59.00
60.00 06000	LABORATORY	5,342	0	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	7,521	2,856	540,073	0	64.00
65.00 06500	RESPIRATORY THERAPY	5,778	252,577	3,510,077	0	65.00
66.00 06600	PHYSICAL THERAPY	930	1,097,699	5,079,208	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	57,520	1,422,915	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	11,719	289,897	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	39,205	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	3,176	229,063	1,117,863	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01 07301	SPECIALTY PHARMACY	0	0	0	0	73.01
74.00 07400	RENAL DIALYSIS	104	0	0	0	74.00
76.00 03330	ENDOSCOPY	7,453	386,012	1,431,991	0	76.00
76.01 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.01
76.02 03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.02
76.03 03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.03
76.04 03953	WOUND CARE	0	152,579	432,787	0	76.04
76.06 03954	IMAGING CENTER	0	950,604	1,886,736	0	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	399,165	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	INFUSION CENTER	0	82,659	116,093	0	90.01
90.26 04975	SPINE CENTER	0	0	204,600	0	90.26
91.00 09100	EMERGENCY	25,409	172,034	6,331,455	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	579,022	17,521,872	116,902,824	-63,219,711	311,737,151
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,514	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1

Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
194.06 07956 PAVILLIONS	0	91,529	0	0	119,153	194.06
194.08 07958 OTHER NRCC	548	85,175	1,719,213	0	2,470,673	194.08
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
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)	14,331,271	17,656,103	6,513,542		63,219,711	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	24.578399	0.997600	0.054910		0.201016	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			101,244		4,493,585	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000854		0.014288	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: 15-0169

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

Worksheet B-1

Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700	491,728					7.00
8.00	00800	2,159	237,529				8.00
9.00	00900	5,377	0	484,192			9.00
10.00	01000	5,970	0	5,970	72,708		10.00
11.00	01100	12,989	0	12,989	0	1,168	11.00
13.00	01300	892	0	892	0	30	13.00
14.00	01400	13,624	0	13,624	0	16	14.00
15.00	01500	6,748	0	6,748	0	59	15.00
16.00	01600	241	0	241	0	0	16.00
17.00	01700	1,596	0	1,596	0	20	17.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	189,707	123,141	189,707	61,592	414	30.00
31.00	03100	36,608	10,996	36,608	6,930	66	31.00
35.00	02060	34,865	12,305	34,865	0	99	35.00
40.00	04000	6,412	1,134	6,412	4,186	28	40.00
43.00	04300	14,181	6,288	14,181	0	22	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	27,310	12,239	27,310	0	64	50.00
51.00	05100	14,660	0	14,660	0	34	51.00
52.00	05200	32,472	14,399	32,472	0	51	52.00
54.00	05400	9,330	17,343	9,330	0	38	54.00
55.00	05500	10,436	3,150	10,436	0	7	55.00
57.00	05700	1,364	0	1,364	0	14	57.00
58.00	05800	5,012	0	5,012	0	8	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	5,342	0	5,342	0	0	60.00
64.00	06400	7,521	0	7,521	0	5	64.00
65.00	06500	5,778	0	5,778	0	37	65.00
66.00	06600	930	0	930	0	14	66.00
67.00	06700	0	0	0	0	16	67.00
68.00	06800	0	0	0	0	3	68.00
69.00	06900	0	0	0	0	1	69.00
70.00	07000	3,176	0	3,176	0	13	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
73.01	07301	0	0	0	0	0	73.01
74.00	07400	104	0	104	0	0	74.00
76.00	03330	7,453	6,062	7,453	0	18	76.00
76.01	03950	0	0	0	0	0	76.01
76.02	03951	0	0	0	0	0	76.02
76.03	03952	0	0	0	0	0	76.03
76.04	03953	0	0	0	0	6	76.04
76.06	03954	0	0	0	0	0	76.06
76.07	03955	0	0	0	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.01	04950	0	0	0	0	2	90.01
90.26	04975	0	0	0	0	0	90.26
91.00	09100	25,409	30,472	25,409	0	83	91.00
92.00	09200	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
114.00	11400						114.00
118.00		487,666	237,529	480,130	72,708	1,168	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	3,514	0	3,514	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.06	07956	0	0	0	0	0	194.06
194.08	07958	548	0	548	0	0	194.08
194.10	07960	0	0	0	0	0	194.10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1

Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	16,120,146	1,192,030	6,566,340	2,608,723	3,136,481	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	32.782648	5.018461	13.561438	35.879449	2,685.343322	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	2,063,495	75,531	257,225	225,179	474,788	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	4.196415	0.317986	0.531246	3.097032	406.496575	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: 15-0169

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

Worksheet B-1

Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description			NURSING ADMINISTRATION  (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE  (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	827					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	47,889,836				14.00
15.00	01500	PHARMACY	0	0	16,349,472			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,692,627,380		16.00
17.00	01700	SOCIAL SERVICE	0	426	0	0	95,509	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	414	2,984,943	0	235,107,685	62,610	30.00
31.00	03100	INTENSIVE CARE UNIT	66	518,660	0	32,434,256	6,930	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	99	866,998	0	119,906,626	13,920	35.00
40.00	04000	SUBPROVIDER - I PF	28	71,089	0	10,065,015	4,186	40.00
43.00	04300	NURSERY	22	161,601	0	11,154,973	7,863	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	64	7,060,217	0	241,411,841	0	50.00
51.00	05100	RECOVERY ROOM	0	271,239	0	41,078,473	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51	370,049	0	25,543,697	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	190,393	0	41,729,784	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	323,410	0	42,843,104	0	55.00
57.00	05700	CT SCAN	0	191,160	0	80,377,004	0	57.00
58.00	05800	MRI	0	39,824	0	28,984,229	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,509	0	4,526,842	0	59.00
60.00	06000	LABORATORY	0	2,020,455	0	135,435,346	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	21,852	0	1,313,965	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	559,110	0	36,633,886	0	65.00
66.00	06600	PHYSICAL THERAPY	0	148,122	0	25,033,802	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	34,505	0	7,469,870	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,030	0	2,305,044	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,085	0	9,585,209	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	149,287	0	14,758,041	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	17,054,271	0	65,355,984	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,020,384	0	44,136,795	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	16,349,472	120,901,298	0	73.00
73.01	07301	SPECIALTY PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	21,591	0	6,064,046	0	74.00
76.00	03330	ENDOSCOPY	0	409,335	0	30,058,909	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04	03953	WOUND CARE	0	138,824	0	4,704,161	0	76.04
76.06	03954	IMAGING CENTER	0	155,296	0	58,112,435	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	10,616	0	29,811,164	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	INFUSION CENTER	0	1,343	0	3,302,119	0	90.01
90.26	04975	SPINE CENTER	0	3,959	0	485,887	0	90.26
91.00	09100	EMERGENCY	83	1,046,208	0	181,995,890	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	827	47,856,791	16,349,472	1,692,627,380	95,509	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,616	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	PAVILLIONS	0	10,356	0	0	0	194.06
194.08	07958	OTHER NRCC	0	15,073	0	0	0	194.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1

Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description			NURSING ADMINISTRATION  (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE  (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
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)	8,988,451	8,645,680	10,989,989	2,988,171	3,088,984	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10,868.743652	0.180533	0.672192	0.001765	32.342334	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	170,923	3,128,667	1,224,616	42,525	91,749	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	206.678356	0.065331	0.074902	0.000025	0.960632	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: 15-0169

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

Worksheet B-1  
Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS			
		SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
		19.00	21.00		22.00
<b>GENERAL SERVICE COST CENTERS</b>					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0			19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV		73,389		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV			73,389	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 03000	ADULTS & PEDIATRICS	0	33,173	33,173	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	35.00
40.00 04000	SUBPROVIDER - IPF	0	33,890	33,890	40.00
43.00 04300	NURSERY	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000	OPERATING ROOM	0	658	658	50.00
51.00 05100	RECOVERY ROOM	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
57.00 05700	CT SCAN	0	0	0	57.00
58.00 05800	MRI	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000	LABORATORY	0	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	2,493	2,493	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
73.01 07301	SPECIALTY PHARMACY	0	0	0	73.01
74.00 07400	RENAL DIALYSIS	0	0	0	74.00
76.00 03330	ENDOSCOPY	0	0	0	76.00
76.01 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.01
76.02 03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.02
76.03 03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.03
76.04 03953	WOUND CARE	0	0	0	76.04
76.06 03954	IMAGING CENTER	0	0	0	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000	CLINIC	0	0	0	90.00
90.01 04950	INFUSION CENTER	0	0	0	90.01
90.26 04975	SPINE CENTER	0	0	0	90.26
91.00 09100	EMERGENCY	0	3,175	3,175	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00 11300	INTEREST EXPENSE				113.00
114.00 11400	UTILIZATION REVIEW-SNF				114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	73,389	73,389	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	194.00



COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1

Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS			
		SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
		19.00	21.00		
194.06 07956 PAVILLIONS	0	0	0		194.06
194.08 07958 OTHER NRCC	0	0	0		194.08
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	0		194.10
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)	0	898,592	1,215,996		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000000	12.244233	16.569186		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	0	10,690	14,466		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	0.145662	0.197114		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: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/30/2022 2:39 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		103,131,979	0	103,131,979	30.00
31.00	03100 INTENSIVE CARE UNIT		13,960,698	0	13,960,698	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		20,513,861	0	20,513,861	35.00
40.00	04000 SUBPROVIDER - IPF		4,748,643	0	4,748,643	40.00
43.00	04300 NURSERY		5,269,410	0	5,269,410	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		27,237,869	0	27,237,869	50.00
51.00	05100 RECOVERY ROOM		6,535,569	0	6,535,569	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		11,492,414	0	11,492,414	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		7,520,984	0	7,520,984	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		4,100,901	0	4,100,901	55.00
57.00	05700 CT SCAN		3,489,808	0	3,489,808	57.00
58.00	05800 MRI		3,318,550	0	3,318,550	58.00
59.00	05900 CARDIAC CATHETERIZATION		230,607	0	230,607	59.00
60.00	06000 LABORATORY		16,051,822	0	16,051,822	60.00
64.00	06400 INTRAVENOUS THERAPY		1,572,462	0	1,572,462	64.00
65.00	06500 RESPIRATORY THERAPY	0	7,793,416	0	7,793,416	65.00
66.00	06600 PHYSICAL THERAPY	0	9,675,128	0	9,675,128	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,704,619	0	2,704,619	67.00
68.00	06800 SPEECH PATHOLOGY	0	551,709	0	551,709	68.00
69.00	06900 ELECTROCARDIOLOGY		650,795	0	650,795	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		3,189,205	0	3,189,205	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		23,676,648	0	23,676,648	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		18,066,200	0	18,066,200	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		31,077,514	0	31,077,514	73.00
73.01	07301 SPECIALTY PHARMACY		0	0	0	73.01
74.00	07400 RENAL DIALYSIS		1,536,166	0	1,536,166	74.00
76.00	03330 ENDOSCOPY		4,425,444	0	4,425,444	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	76.03
76.04	03953 WOUND CARE		1,631,149	0	1,631,149	76.04
76.06	03954 IMAGING CENTER		5,399,013	0	5,399,013	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER		14,485,574	0	14,485,574	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC		0	0	0	90.00
90.01	04950 INFUSION CENTER		292,416	0	292,416	90.01
90.26	04975 SPINE CENTER		324,838	0	324,838	90.26
91.00	09100 EMERGENCY		17,437,016	0	17,437,016	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		10,157,263	0	10,157,263	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
114.00	11400 UTILIZATION REVIEW-SNF					114.00
200.00	Subtotal (see instructions)		382,249,690	0	382,249,690	200.00
201.00	Less Observation Beds		10,157,263	0	10,157,263	201.00
202.00	Total (see instructions)		372,092,427	0	372,092,427	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0169		Period: From 01/01/2021 To 12/31/2021		Worksheet C Part I Date/Time Prepared: 5/30/2022 2:39 pm		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	223,149,374		223,149,374				30.00
31.00	03100	INTENSIVE CARE UNIT	32,434,256		32,434,256				31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	119,906,626		119,906,626				35.00
40.00	04000	SUBPROVIDER - IPF	10,065,015		10,065,015				40.00
43.00	04300	NURSERY	11,154,973		11,154,973				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	143,426,417	97,985,424	241,411,841	0.112827	0.000000		50.00
51.00	05100	RECOVERY ROOM	20,772,557	20,305,916	41,078,473	0.159100	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,543,697	0	25,543,697	0.449912	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,536,072	29,193,712	41,729,784	0.180231	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	14,897,893	27,945,211	42,843,104	0.095719	0.000000		55.00
57.00	05700	CT SCAN	27,483,098	52,893,906	80,377,004	0.043418	0.000000		57.00
58.00	05800	MRI	5,868,933	23,115,296	28,984,229	0.114495	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	4,526,842	0	4,526,842	0.050942	0.000000		59.00
60.00	06000	LABORATORY	89,019,418	46,415,928	135,435,346	0.118520	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	1,282,401	31,564	1,313,965	1.196731	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	34,493,841	2,140,045	36,633,886	0.212738	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	4,423,965	20,609,837	25,033,802	0.386483	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,210,145	3,259,725	7,469,870	0.362070	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	1,543,137	761,907	2,305,044	0.239349	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	8,097,727	1,487,482	9,585,209	0.067896	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,170,706	13,587,335	14,758,041	0.216099	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,986,907	24,369,077	65,355,984	0.362272	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,739,260	19,397,535	44,136,795	0.409323	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	94,573,572	26,327,726	120,901,298	0.257049	0.000000		73.00
73.01	07301	SPECIALTY PHARMACY	0	0	0	0.000000	0.000000		73.01
74.00	07400	RENAL DIALYSIS	6,064,046	0	6,064,046	0.253324	0.000000		74.00
76.00	03330	ENDOSCOPY	6,794,215	23,264,694	30,058,909	0.147226	0.000000		76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000		76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000		76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000		76.03
76.04	03953	WOUND CARE	950,815	3,753,346	4,704,161	0.346746	0.000000		76.04
76.06	03954	IMAGING CENTER	418,599	57,693,836	58,112,435	0.092906	0.000000		76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	22,484	29,788,680	29,811,164	0.485911	0.000000		76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>									
90.00	09000	CLINIC	0	0	0	0.000000	0.000000		90.00
90.01	04950	INFUSION CENTER	144	3,301,975	3,302,119	0.088554	0.000000		90.01
90.26	04975	SPINE CENTER	0	485,887	485,887	0.668546	0.000000		90.26
91.00	09100	EMERGENCY	43,557,868	138,438,022	181,995,890	0.095810	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,730,215	9,228,096	11,958,311	0.849389	0.000000		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>									
113.00	11300	INTEREST EXPENSE							113.00
114.00	11400	UTILIZATION REVIEW-SNF							114.00
200.00		Subtotal (see instructions)	1,016,845,218	675,782,162	1,692,627,380				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	1,016,845,218	675,782,162	1,692,627,380				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/30/2022 2:39 pm
Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital PPS
			11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.112827		50.00
51.00	05100	RECOVERY ROOM	0.159100		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.449912		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180231		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.095719		55.00
57.00	05700	CT SCAN	0.043418		57.00
58.00	05800	MRI	0.114495		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.050942		59.00
60.00	06000	LABORATORY	0.118520		60.00
64.00	06400	INTRAVENOUS THERAPY	1.196731		64.00
65.00	06500	RESPIRATORY THERAPY	0.212738		65.00
66.00	06600	PHYSICAL THERAPY	0.386483		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.362070		67.00
68.00	06800	SPEECH PATHOLOGY	0.239349		68.00
69.00	06900	ELECTROCARDIOLOGY	0.067896		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.216099		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.362272		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.409323		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257049		73.00
73.01	07301	SPECIALTY PHARMACY	0.000000		73.01
74.00	07400	RENAL DIALYSIS	0.253324		74.00
76.00	03330	ENDOSCOPY	0.147226		76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.03
76.04	03953	WOUND CARE	0.346746		76.04
76.06	03954	IMAGING CENTER	0.092906		76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.485911		76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000		90.00
90.01	04950	INFUSION CENTER	0.088554		90.01
90.26	04975	SPINE CENTER	0.668546		90.26
91.00	09100	EMERGENCY	0.095810		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.849389		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
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: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/30/2022 2:39 pm		
			Title XIX	Hospital	PPS		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	104,087,807		0	104,087,807	30.00
31.00	03100	INTENSIVE CARE UNIT	13,960,698		0	13,960,698	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	20,513,861		0	20,513,861	35.00
40.00	04000	SUBPROVIDER - IPF	5,725,129		0	5,725,129	40.00
43.00	04300	NURSERY	5,269,410		0	5,269,410	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	27,256,829		0	27,256,829	50.00
51.00	05100	RECOVERY ROOM	6,535,569		0	6,535,569	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,492,414		0	11,492,414	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,520,984		0	7,520,984	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,100,901		0	4,100,901	55.00
57.00	05700	CT SCAN	3,489,808		0	3,489,808	57.00
58.00	05800	MRI	3,318,550		0	3,318,550	58.00
59.00	05900	CARDIAC CATHETERIZATION	230,607		0	230,607	59.00
60.00	06000	LABORATORY	16,051,822		0	16,051,822	60.00
64.00	06400	INTRAVENOUS THERAPY	1,572,462		0	1,572,462	64.00
65.00	06500	RESPIRATORY THERAPY	7,793,416	0	0	7,793,416	65.00
66.00	06600	PHYSICAL THERAPY	9,746,960	0	0	9,746,960	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,704,619	0	0	2,704,619	67.00
68.00	06800	SPEECH PATHOLOGY	551,709	0	0	551,709	68.00
69.00	06900	ELECTROCARDIOLOGY	650,795		0	650,795	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,189,205		0	3,189,205	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,676,648		0	23,676,648	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,066,200		0	18,066,200	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,077,514		0	31,077,514	73.00
73.01	07301	SPECIALTY PHARMACY	0		0	0	73.01
74.00	07400	RENAL DIALYSIS	1,536,166		0	1,536,166	74.00
76.00	03330	ENDOSCOPY	4,425,444		0	4,425,444	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	76.03
76.04	03953	WOUND CARE	1,631,149		0	1,631,149	76.04
76.06	03954	IMAGING CENTER	5,399,013		0	5,399,013	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	14,485,574		0	14,485,574	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0		0	0	90.00
90.01	04950	INFUSION CENTER	292,416		0	292,416	90.01
90.26	04975	SPIRE CENTER	324,838		0	324,838	90.26
91.00	09100	EMERGENCY	17,528,498		0	17,528,498	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,157,263		0	10,157,263	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
200.00		Subtotal (see instructions)	384,364,278	0	0	384,364,278	200.00
201.00		Less Observation Beds	10,157,263		0	10,157,263	201.00
202.00		Total (see instructions)	374,207,015	0	0	374,207,015	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0169

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2022 2:39 pm

		Title XIX			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	223,149,374		223,149,374		30.00
31.00	03100	INTENSIVE CARE UNIT	32,434,256		32,434,256		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	119,906,626		119,906,626		35.00
40.00	04000	SUBPROVIDER - IPF	10,065,015		10,065,015		40.00
43.00	04300	NURSERY	11,154,973		11,154,973		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	143,426,417	97,985,424	241,411,841	0.112906	50.00
51.00	05100	RECOVERY ROOM	20,772,557	20,305,916	41,078,473	0.159100	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,543,697	0	25,543,697	0.449912	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,536,072	29,193,712	41,729,784	0.180231	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	14,897,893	27,945,211	42,843,104	0.095719	55.00
57.00	05700	CT SCAN	27,483,098	52,893,906	80,377,004	0.043418	57.00
58.00	05800	MRI	5,868,933	23,115,296	28,984,229	0.114495	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,526,842	0	4,526,842	0.050942	59.00
60.00	06000	LABORATORY	89,019,418	46,415,928	135,435,346	0.118520	60.00
64.00	06400	INTRAVENOUS THERAPY	1,282,401	31,564	1,313,965	1.196731	64.00
65.00	06500	RESPIRATORY THERAPY	34,493,841	2,140,045	36,633,886	0.212738	65.00
66.00	06600	PHYSICAL THERAPY	4,423,965	20,609,837	25,033,802	0.389352	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,210,145	3,259,725	7,469,870	0.362070	67.00
68.00	06800	SPEECH PATHOLOGY	1,543,137	761,907	2,305,044	0.239349	68.00
69.00	06900	ELECTROCARDIOLOGY	8,097,727	1,487,482	9,585,209	0.067896	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,170,706	13,587,335	14,758,041	0.216099	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,986,907	24,369,077	65,355,984	0.362272	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,739,260	19,397,535	44,136,795	0.409323	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	94,573,572	26,327,726	120,901,298	0.257049	73.00
73.01	07301	SPECIALTY PHARMACY	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	6,064,046	0	6,064,046	0.253324	74.00
76.00	03330	ENDOSCOPY	6,794,215	23,264,694	30,058,909	0.147226	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.03
76.04	03953	WOUND CARE	950,815	3,753,346	4,704,161	0.346746	76.04
76.06	03954	IMAGING CENTER	418,599	57,693,836	58,112,435	0.092906	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	22,484	29,788,680	29,811,164	0.485911	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	04950	INFUSION CENTER	144	3,301,975	3,302,119	0.088554	90.01
90.26	04975	SPINE CENTER	0	485,887	485,887	0.668546	90.26
91.00	09100	EMERGENCY	43,557,868	138,438,022	181,995,890	0.096313	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,730,215	9,228,096	11,958,311	0.849389	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
200.00		Subtotal (see instructions)	1,016,845,218	675,782,162	1,692,627,380		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	1,016,845,218	675,782,162	1,692,627,380		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/30/2022 2:39 pm
Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital PPS
			11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.112906		50.00
51.00	05100	RECOVERY ROOM	0.159100		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.449912		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180231		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.095719		55.00
57.00	05700	CT SCAN	0.043418		57.00
58.00	05800	MRI	0.114495		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.050942		59.00
60.00	06000	LABORATORY	0.118520		60.00
64.00	06400	INTRAVENOUS THERAPY	1.196731		64.00
65.00	06500	RESPIRATORY THERAPY	0.212738		65.00
66.00	06600	PHYSICAL THERAPY	0.389352		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.362070		67.00
68.00	06800	SPEECH PATHOLOGY	0.239349		68.00
69.00	06900	ELECTROCARDIOLOGY	0.067896		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.216099		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.362272		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.409323		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257049		73.00
73.01	07301	SPECIALTY PHARMACY	0.000000		73.01
74.00	07400	RENAL DIALYSIS	0.253324		74.00
76.00	03330	ENDOSCOPY	0.147226		76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.03
76.04	03953	WOUND CARE	0.346746		76.04
76.06	03954	IMAGING CENTER	0.092906		76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.485911		76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000		90.00
90.01	04950	INFUSION CENTER	0.088554		90.01
90.26	04975	SPINE CENTER	0.668546		90.26
91.00	09100	EMERGENCY	0.096313		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.849389		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-0169

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

Worksheet C Part II Date/Time Prepared: 5/30/2022 2:39 pm

Cost Center Description			Title XIX			Hospital		PPS
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	27,256,829	4,657,309	22,599,520	0	0	50.00
51.00	05100	RECOVERY ROOM	6,535,569	538,393	5,997,176	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,492,414	1,225,795	10,266,619	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,520,984	718,686	6,802,298	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,100,901	778,026	3,322,875	0	0	55.00
57.00	05700	CT SCAN	3,489,808	330,276	3,159,532	0	0	57.00
58.00	05800	MRI	3,318,550	687,568	2,630,982	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	230,607	4,506	226,101	0	0	59.00
60.00	06000	LABORATORY	16,051,822	472,771	15,579,051	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,572,462	241,540	1,330,922	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	7,793,416	563,160	7,230,256	0	0	65.00
66.00	06600	PHYSICAL THERAPY	9,746,960	1,255,949	8,491,011	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,704,619	98,976	2,605,643	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	551,709	20,079	531,630	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	650,795	8,257	642,538	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,189,205	373,094	2,816,111	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,676,648	1,359,449	22,317,199	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,066,200	1,037,773	17,028,427	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,077,514	1,464,074	29,613,440	0	0	73.00
73.01	07301	SPECIALTY PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	1,536,166	22,654	1,513,512	0	0	74.00
76.00	03330	ENDOSCOPY	4,425,444	687,556	3,737,888	0	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04	03953	WOUND CARE	1,631,149	183,027	1,448,122	0	0	76.04
76.06	03954	IMAGING CENTER	5,399,013	1,024,209	4,374,804	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	14,485,574	571,326	13,914,248	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	INFUSION CENTER	292,416	86,887	205,529	0	0	90.01
90.26	04975	SPI NE CENTER	324,838	4,292	320,546	0	0	90.26
91.00	09100	EMERGENCY	17,528,498	1,227,310	16,301,188	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,157,263	801,926	9,355,337	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (sum of lines 50 thru 199)	234,807,373	20,444,868	214,362,505	0	0	200.00
201.00		Less Observation Beds	10,157,263	801,926	9,355,337	0	0	201.00
202.00		Total (line 200 minus line 201)	224,650,110	19,642,942	205,007,168	0	0	202.00



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

Provider CCN: 15-0169

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

Worksheet C  
Part II  
Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	27,256,829	241,411,841	0.112906		50.00
51.00	05100 RECOVERY ROOM	6,535,569	41,078,473	0.159100		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	11,492,414	25,543,697	0.449912		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,520,984	41,729,784	0.180231		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	4,100,901	42,843,104	0.095719		55.00
57.00	05700 CT SCAN	3,489,808	80,377,004	0.043418		57.00
58.00	05800 MRI	3,318,550	28,984,229	0.114495		58.00
59.00	05900 CARDIAC CATHETERIZATION	230,607	4,526,842	0.050942		59.00
60.00	06000 LABORATORY	16,051,822	135,435,346	0.118520		60.00
64.00	06400 INTRAVENOUS THERAPY	1,572,462	1,313,965	1.196731		64.00
65.00	06500 RESPIRATORY THERAPY	7,793,416	36,633,886	0.212738		65.00
66.00	06600 PHYSICAL THERAPY	9,746,960	25,033,802	0.389352		66.00
67.00	06700 OCCUPATIONAL THERAPY	2,704,619	7,469,870	0.362070		67.00
68.00	06800 SPEECH PATHOLOGY	551,709	2,305,044	0.239349		68.00
69.00	06900 ELECTROCARDIOLOGY	650,795	9,585,209	0.067896		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	3,189,205	14,758,041	0.216099		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	23,676,648	65,355,984	0.362272		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	18,066,200	44,136,795	0.409323		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	31,077,514	120,901,298	0.257049		73.00
73.01	07301 SPECIALTY PHARMACY	0	0	0.000000		73.01
74.00	07400 RENAL DIALYSIS	1,536,166	6,064,046	0.253324		74.00
76.00	03330 ENDOSCOPY	4,425,444	30,058,909	0.147226		76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000		76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000		76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000		76.03
76.04	03953 WOUND CARE	1,631,149	4,704,161	0.346746		76.04
76.06	03954 IMAGING CENTER	5,399,013	58,112,435	0.092906		76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	14,485,574	29,811,164	0.485911		76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0	0.000000		90.00
90.01	04950 INFUSION CENTER	292,416	3,302,119	0.088554		90.01
90.26	04975 SPINE CENTER	324,838	485,887	0.668546		90.26
91.00	09100 EMERGENCY	17,528,498	181,995,890	0.096313		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	10,157,263	11,958,311	0.849389		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
114.00	11400 UTILIZATION REVIEW-SNF					114.00
200.00	Subtotal (sum of lines 50 thru 199)	234,807,373	1,295,917,136			200.00
201.00	Less Observation Beds	10,157,263	0			201.00
202.00	Total (line 200 minus line 201)	224,650,110	1,295,917,136			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Prepared: 5/30/2022 2:39 pm
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Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	8,142,381	0	8,142,381	69,450	117.24	30.00
31.00	INTENSIVE CARE UNIT	1,488,315		1,488,315	6,930	214.76	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	1,525,565		1,525,565	13,920	109.60	35.00
40.00	SUBPROVIDER - IPF	281,869	0	281,869	4,172	67.56	40.00
43.00	NURSERY	542,704		542,704	7,863	69.02	43.00
200.00	Total (lines 30 through 199)	11,980,834		11,980,834	102,335		200.00

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	6.00	7.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	15,502	1,817,454				30.00
31.00	INTENSIVE CARE UNIT	1,771	380,340				31.00
35.00	NEONATAL INTENSIVE CARE UNIT	0	0				35.00
40.00	SUBPROVIDER - IPF	1,866	126,067				40.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	19,139	2,323,861				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0169

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

Worksheet D  
Part II  
Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description			Title XVIII			Hospital		PPS	
			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		
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	4,657,309	241,411,841	0.019292	40,193,967	775,422	50.00	
51.00	05100	RECOVERY ROOM	538,393	41,078,473	0.013106	5,118,114	67,078	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,225,795	25,543,697	0.047988	46,798	2,246	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	718,686	41,729,784	0.017222	3,057,293	52,653	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	778,026	42,843,104	0.018160	4,915,807	89,271	55.00	
57.00	05700	CT SCAN	330,276	80,377,004	0.004109	8,488,678	34,880	57.00	
58.00	05800	MRI	687,568	28,984,229	0.023722	1,515,129	35,942	58.00	
59.00	05900	CARDIAC CATHETERIZATION	4,506	4,526,842	0.000995	204,456	203	59.00	
60.00	06000	LABORATORY	472,771	135,435,346	0.003491	23,717,235	82,797	60.00	
64.00	06400	INTRAVENOUS THERAPY	241,540	1,313,965	0.183825	257,903	47,409	64.00	
65.00	06500	RESPIRATORY THERAPY	563,160	36,633,886	0.015373	6,821,761	104,871	65.00	
66.00	06600	PHYSICAL THERAPY	1,255,949	25,033,802	0.050170	1,628,163	81,685	66.00	
67.00	06700	OCCUPATIONAL THERAPY	98,976	7,469,870	0.013250	1,253,402	16,608	67.00	
68.00	06800	SPEECH PATHOLOGY	20,079	2,305,044	0.008711	392,098	3,416	68.00	
69.00	06900	ELECTROCARDIOLOGY	8,257	9,585,209	0.000861	3,977,104	3,424	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	373,094	14,758,041	0.025281	276,651	6,994	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,359,449	65,355,984	0.020801	7,759,087	161,397	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,037,773	44,136,795	0.023513	9,432,560	221,788	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,464,074	120,901,298	0.012110	20,894,365	253,031	73.00	
73.01	07301	SPECIALTY PHARMACY	0	0	0.000000	0	0	73.01	
74.00	07400	RENAL DIALYSIS	22,654	6,064,046	0.003736	1,652,735	6,175	74.00	
76.00	03330	ENDOSCOPY	687,556	30,058,909	0.022874	2,198,555	50,290	76.00	
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.01	
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.02	
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.03	
76.04	03953	WOUND CARE	183,027	4,704,161	0.038907	296,587	11,539	76.04	
76.06	03954	IMAGING CENTER	1,024,209	58,112,435	0.017625	32,139	566	76.06	
76.07	03955	BREAST DIAGNOSTIC CENTER	571,326	29,811,164	0.019165	0	0	76.07	
<b>OUTPATIENT SERVICE COST CENTERS</b>									
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00	
90.01	04950	INFUSION CENTER	86,887	3,302,119	0.026312	0	0	90.01	
90.26	04975	SPINE CENTER	4,292	485,887	0.008833	0	0	90.26	
91.00	09100	EMERGENCY	1,227,310	181,995,890	0.006744	12,609,617	85,039	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	801,926	11,958,311	0.067060	1,226,339	82,238	92.00	
200.00		Total (lines 50 through 199)	20,444,868	1,295,917,136		157,966,543	2,276,962	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Prepared: 5/30/2022 2:39 pm
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Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	69,450	0.00	15,502	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	6,930	0.00	1,771	31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	13,920	0.00	0	35.00	
40.00	04000	SUBPROVIDER - IPF	0	0	4,172	0.00	1,866	40.00	
43.00	04300	NURSERY	0	0	7,863	0.00	0	43.00	
200.00		Total (lines 30 through 199)	0	0	102,335		19,139	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0						35.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/30/2022 2:39 pm
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Cost Center Description	Title XVIII			Hospital		Allied Health Post-Stepdown Adjustments	Allied Health PPS	
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program					
	1.00	2A	2.00	3A	3.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	SPECIALTY PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04	03953	WOUND CARE	0	0	0	0	0	76.04
76.06	03954	IMAGING CENTER	0	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	0	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	INFUSION CENTER	0	0	0	0	0	90.01
90.26	04975	SPINE CENTER	0	0	0	0	0	90.26
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	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: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/30/2022 2:39 pm
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Title XVIII		Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
				Hospital	PPS	
	4.00	5.00	6.00	Total Charges (from Wkst. C, Part I, col. 8)	7.00	8.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	241,411,841	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	41,078,473	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	25,543,697	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	41,729,784	0.000000	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	42,843,104	0.000000	55.00
57.00 05700 CT SCAN	0	0	0	80,377,004	0.000000	57.00
58.00 05800 MRI	0	0	0	28,984,229	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	4,526,842	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	135,435,346	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	1,313,965	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	36,633,886	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	25,033,802	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	7,469,870	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	2,305,044	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	9,585,209	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	14,758,041	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	65,355,984	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	44,136,795	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	120,901,298	0.000000	73.00
73.01 07301 SPECIALTY PHARMACY	0	0	0	0	0.000000	73.01
74.00 07400 RENAL DIALYSIS	0	0	0	6,064,046	0.000000	74.00
76.00 03330 ENDOSCOPY	0	0	0	30,058,909	0.000000	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.03
76.04 03953 WOUND CARE	0	0	0	4,704,161	0.000000	76.04
76.06 03954 IMAGING CENTER	0	0	0	58,112,435	0.000000	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0	0	29,811,164	0.000000	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0.000000	90.00
90.01 04950 INFUSION CENTER	0	0	0	3,302,119	0.000000	90.01
90.26 04975 SPINE CENTER	0	0	0	485,887	0.000000	90.26
91.00 09100 EMERGENCY	0	0	0	181,995,890	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	11,958,311	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	0	1,295,917,136		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/30/2022 2:39 pm
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Cost Center Description		Title XVIII					Hospital	PPS
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000 OPERATING ROOM	0.000000	40,193,967	0	18,546,696	0	50.00	
51.00	05100 RECOVERY ROOM	0.000000	5,118,114	0	3,186,179	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	46,798	0	0	0	52.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	3,057,293	0	4,239,977	0	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	4,915,807	0	9,321,581	0	55.00	
57.00	05700 CT SCAN	0.000000	8,488,678	0	7,790,625	0	57.00	
58.00	05800 MRI	0.000000	1,515,129	0	7,895,151	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	204,456	0	0	0	59.00	
60.00	06000 LABORATORY	0.000000	23,717,235	0	6,729,131	0	60.00	
64.00	06400 INTRAVENOUS THERAPY	0.000000	257,903	0	0	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0.000000	6,821,761	0	232,053	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	1,628,163	0	88,578	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,253,402	0	18,440	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	392,098	0	4,164	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	3,977,104	0	218,270	0	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	276,651	0	2,429,287	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	7,759,087	0	4,787,292	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	9,432,560	0	5,360,559	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	20,894,365	0	8,700,689	0	73.00	
73.01	07301 SPECIALTY PHARMACY	0.000000	0	0	0	0	73.01	
74.00	07400 RENAL DIALYSIS	0.000000	1,652,735	0	0	0	74.00	
76.00	03330 ENDOSCOPY	0.000000	2,198,555	0	5,862,350	0	76.00	
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.01	
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.02	
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.03	
76.04	03953 WOUND CARE	0.000000	296,587	0	1,048,890	0	76.04	
76.06	03954 IMAGING CENTER	0.000000	32,139	0	13,547,682	0	76.06	
76.07	03955 BREAST DIAGNOSTIC CENTER	0.000000	0	0	2,737,631	0	76.07	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00	
90.01	04950 INFUSION CENTER	0.000000	0	0	220,024	0	90.01	
90.26	04975 SPINE CENTER	0.000000	0	0	0	0	90.26	
91.00	09100 EMERGENCY	0.000000	12,609,617	0	13,851,809	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,226,339	0	3,787,588	0	92.00	
200.00	Total (lines 50 through 199)		157,966,543	0	120,604,646	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/30/2022 2:39 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.112827	18,546,696	0	0	2,092,568	50.00
51.00	05100	RECOVERY ROOM	0.159100	3,186,179	0	0	506,921	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.449912	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180231	4,239,977	0	0	764,175	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.095719	9,321,581	0	0	892,252	55.00
57.00	05700	CT SCAN	0.043418	7,790,625	0	0	338,253	57.00
58.00	05800	MRI	0.114495	7,895,151	0	0	903,955	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.050942	0	0	0	0	59.00
60.00	06000	LABORATORY	0.118520	6,729,131	0	0	797,537	60.00
64.00	06400	INTRAVENOUS THERAPY	1.196731	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.212738	232,053	0	0	49,366	65.00
66.00	06600	PHYSICAL THERAPY	0.386483	88,578	0	0	34,234	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.362070	18,440	0	0	6,677	67.00
68.00	06800	SPEECH PATHOLOGY	0.239349	4,164	0	0	997	68.00
69.00	06900	ELECTROCARDIOLOGY	0.067896	218,270	0	0	14,820	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.216099	2,429,287	0	0	524,966	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.362272	4,787,292	0	0	1,734,302	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.409323	5,360,559	0	0	2,194,200	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257049	8,700,689	0	40,791	2,236,503	73.00
73.01	07301	SPECIALTY PHARMACY	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.253324	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.147226	5,862,350	0	0	863,090	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.03
76.04	03953	WOUND CARE	0.346746	1,048,890	0	0	363,698	76.04
76.06	03954	IMAGING CENTER	0.092906	13,547,682	0	0	1,258,661	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.485911	2,737,631	0	0	1,330,245	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	INFUSION CENTER	0.088554	220,024	0	0	19,484	90.01
90.26	04975	SPINE CENTER	0.668546	0	0	0	0	90.26
91.00	09100	EMERGENCY	0.095810	13,851,809	0	0	1,327,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.849389	3,787,588	0	0	3,217,136	92.00
200.00		Subtotal (see instructions)		120,604,646	0	40,791	21,471,182	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		120,604,646	0	40,791	21,471,182	202.00



APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/30/2022 2:39 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10,485		73.00
73.01 07301 SPECIALTY PHARMACY	0	0		73.01
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03330 ENDOSCOPY	0	0		76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.03
76.04 03953 WOUND CARE	0	0		76.04
76.06 03954 IMAGING CENTER	0	0		76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0		76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
90.01 04950 INFUSION CENTER	0	0		90.01
90.26 04975 SPINE CENTER	0	0		90.26
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	10,485		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	10,485		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Prepared: 5/30/2022 2:39 pm
Title XVIII			Subprovider - IPF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	4,657,309	241,411,841	0.019292	4,590	89	50.00
51.00	05100 RECOVERY ROOM	538,393	41,078,473	0.013106	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,225,795	25,543,697	0.047988	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	718,686	41,729,784	0.017222	21,259	366	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	778,026	42,843,104	0.018160	0	0	55.00
57.00	05700 CT SCAN	330,276	80,377,004	0.004109	58,939	242	57.00
58.00	05800 MRI	687,568	28,984,229	0.023722	11,329	269	58.00
59.00	05900 CARDIAC CATHETERIZATION	4,506	4,526,842	0.000995	0	0	59.00
60.00	06000 LABORATORY	472,771	135,435,346	0.003491	596,721	2,083	60.00
64.00	06400 INTRAVENOUS THERAPY	241,540	1,313,965	0.183825	3,255	598	64.00
65.00	06500 RESPIRATORY THERAPY	563,160	36,633,886	0.015373	5,568	86	65.00
66.00	06600 PHYSICAL THERAPY	1,255,949	25,033,802	0.050170	27,835	1,396	66.00
67.00	06700 OCCUPATIONAL THERAPY	98,976	7,469,870	0.013250	24,417	324	67.00
68.00	06800 SPEECH PATHOLOGY	20,079	2,305,044	0.008711	5,184	45	68.00
69.00	06900 ELECTROCARDIOLOGY	8,257	9,585,209	0.000861	21,525	19	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	373,094	14,758,041	0.025281	5,614	142	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,359,449	65,355,984	0.020801	511	11	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,037,773	44,136,795	0.023513	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,464,074	120,901,298	0.012110	384,857	4,661	73.00
73.01	07301 SPECIALTY PHARMACY	0	0	0.000000	0	0	73.01
74.00	07400 RENAL DIALYSIS	22,654	6,064,046	0.003736	0	0	74.00
76.00	03330 ENDOSCOPY	687,556	30,058,909	0.022874	0	0	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.03
76.04	03953 WOUND CARE	183,027	4,704,161	0.038907	0	0	76.04
76.06	03954 IMAGING CENTER	1,024,209	58,112,435	0.017625	0	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	571,326	29,811,164	0.019165	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	04950 INFUSION CENTER	86,887	3,302,119	0.026312	0	0	90.01
90.26	04975 SPINE CENTER	4,292	485,887	0.008833	0	0	90.26
91.00	09100 EMERGENCY	1,227,310	181,995,890	0.006744	234,029	1,578	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	11,958,311	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	19,642,942	1,295,917,136		1,405,633	11,909	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/30/2022 2:39 pm
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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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301 SPECIALTY PHARMACY	0	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03330 ENDOSCOPY	0	0	0	0	0	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04	03953 WOUND CARE	0	0	0	0	0	76.04
76.06	03954 IMAGING CENTER	0	0	0	0	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0	0	0	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	04950 INFUSION CENTER	0	0	0	0	0	90.01
90.26	04975 SPINE CENTER	0	0	0	0	0	90.26
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	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: 15-0169 Component CCN: 15-S169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/30/2022 2:39 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col.s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col.s. 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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	241,411,841	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	41,078,473	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	25,543,697	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	41,729,784	0.000000	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	42,843,104	0.000000	55.00
57.00 05700 CT SCAN	0	0	0	80,377,004	0.000000	57.00
58.00 05800 MRI	0	0	0	28,984,229	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	4,526,842	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	135,435,346	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	1,313,965	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	36,633,886	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	25,033,802	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	7,469,870	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	2,305,044	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	9,585,209	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	14,758,041	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	65,355,984	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	44,136,795	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	120,901,298	0.000000	73.00
73.01 07301 SPECIALTY PHARMACY	0	0	0	0	0.000000	73.01
74.00 07400 RENAL DIALYSIS	0	0	0	6,064,046	0.000000	74.00
76.00 03330 ENDOSCOPY	0	0	0	30,058,909	0.000000	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.03
76.04 03953 WOUND CARE	0	0	0	4,704,161	0.000000	76.04
76.06 03954 IMAGING CENTER	0	0	0	58,112,435	0.000000	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0	0	29,811,164	0.000000	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0.000000	90.00
90.01 04950 INFUSION CENTER	0	0	0	3,302,119	0.000000	90.01
90.26 04975 SPINE CENTER	0	0	0	485,887	0.000000	90.26
91.00 09100 EMERGENCY	0	0	0	181,995,890	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	11,958,311	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	0	1,295,917,136		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0169 Component CCN: 15-S169		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/30/2022 2:39 pm	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	4,590	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	21,259	0	267	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700 CT SCAN	0.000000	58,939	0	1,534	0	57.00
58.00	05800 MRI	0.000000	11,329	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	596,721	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	3,255	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	5,568	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	27,835	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	24,417	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	5,184	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	21,525	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	5,614	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	511	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	384,857	0	979	0	73.00
73.01	07301 SPECIALTY PHARMACY	0.000000	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03330 ENDOSCOPY	0.000000	0	0	0	0	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.03
76.04	03953 WOUND CARE	0.000000	0	0	0	0	76.04
76.06	03954 IMAGING CENTER	0.000000	0	0	0	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.000000	0	0	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 INFUSION CENTER	0.000000	0	0	0	0	90.01
90.26	04975 SPINE CENTER	0.000000	0	0	0	0	90.26
91.00	09100 EMERGENCY	0.000000	234,029	0	624	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)		1,405,633	0	3,404	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/30/2022 2:39 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.112827	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.159100	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.449912	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.180231	267	0	0	48	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.095719	0	0	0	0	55.00
57.00 05700 CT SCAN	0.043418	1,534	0	0	67	57.00
58.00 05800 MRI	0.114495	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.050942	0	0	0	0	59.00
60.00 06000 LABORATORY	0.118520	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	1.196731	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.212738	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.386483	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.362070	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.239349	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.067896	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.216099	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.362272	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.409323	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.257049	979	0	570	252	73.00
73.01 07301 SPECIALTY PHARMACY	0.000000	0	0	0	0	73.01
74.00 07400 RENAL DIALYSIS	0.253324	0	0	0	0	74.00
76.00 03330 ENDOSCOPY	0.147226	0	0	0	0	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.03
76.04 03953 WOUND CARE	0.346746	0	0	0	0	76.04
76.06 03954 IMAGING CENTER	0.092906	0	0	0	0	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0.485911	0	0	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
90.01 04950 INFUSION CENTER	0.088554	0	0	0	0	90.01
90.26 04975 SPINE CENTER	0.668546	0	0	0	0	90.26
91.00 09100 EMERGENCY	0.095810	624	0	0	60	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.849389	0	0	0	0	92.00
200.00 Subtotal (see instructions)		3,404	0	570	427	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 - line 201)		3,404	0	570	427	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/30/2022 2:39 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	147	73.00
73.01 07301 SPECIALTY PHARMACY	0	0	73.01
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03330 ENDOSCOPY	0	0	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.03
76.04 03953 WOUND CARE	0	0	76.04
76.06 03954 IMAGING CENTER	0	0	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00 09000 CLINIC	0	0	90.00
90.01 04950 INFUSION CENTER	0	0	90.01
90.26 04975 SPINE CENTER	0	0	90.26
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	147	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	147	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Prepared: 5/30/2022 2:39 pm
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Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	8,142,381	0	8,142,381	69,450	117.24	30.00	
31.00	INTENSIVE CARE UNIT	1,488,315		1,488,315	6,930	214.76	31.00	
35.00	NEONATAL INTENSIVE CARE UNIT	1,525,565		1,525,565	13,920	109.60	35.00	
40.00	SUBPROVIDER - IPF	281,869	0	281,869	4,172	67.56	40.00	
43.00	NURSERY	542,704		542,704	7,863	69.02	43.00	
200.00	Total (lines 30 through 199)	11,980,834		11,980,834	102,335		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,232	261,680					30.00
31.00	INTENSIVE CARE UNIT	2,067	443,909					31.00
35.00	NEONATAL INTENSIVE CARE UNIT	0	0					35.00
40.00	SUBPROVIDER - IPF	0	0					40.00
43.00	NURSERY	3,254	224,591					43.00
200.00	Total (lines 30 through 199)	7,553	930,180					200.00



APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Prepared: 5/30/2022 2:39 pm
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Cost Center Description			Title XIX			Hospital		PPS	
			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		
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	4,657,309	241,411,841	0.019292	3,286,839	63,410	50.00	
51.00	05100	RECOVERY ROOM	538,393	41,078,473	0.013106	542,668	7,112	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,225,795	25,543,697	0.047988	525,112	25,199	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	718,686	41,729,784	0.017222	733,241	12,628	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	778,026	42,843,104	0.018160	493,072	8,954	55.00	
57.00	05700	CT SCAN	330,276	80,377,004	0.004109	1,353,120	5,560	57.00	
58.00	05800	MRI	687,568	28,984,229	0.023722	344,863	8,181	58.00	
59.00	05900	CARDIAC CATHETERIZATION	4,506	4,526,842	0.000995	269,424	268	59.00	
60.00	06000	LABORATORY	472,771	135,435,346	0.003491	4,695,577	16,392	60.00	
64.00	06400	INTRAVENOUS THERAPY	241,540	1,313,965	0.183825	53,667	9,865	64.00	
65.00	06500	RESPIRATORY THERAPY	563,160	36,633,886	0.015373	2,919,084	44,875	65.00	
66.00	06600	PHYSICAL THERAPY	1,255,949	25,033,802	0.050170	143,105	7,180	66.00	
67.00	06700	OCCUPATIONAL THERAPY	98,976	7,469,870	0.013250	228,561	3,028	67.00	
68.00	06800	SPEECH PATHOLOGY	20,079	2,305,044	0.008711	106,529	928	68.00	
69.00	06900	ELECTROCARDIOLOGY	8,257	9,585,209	0.000861	385,297	332	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	373,094	14,758,041	0.025281	71,695	1,813	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,359,449	65,355,984	0.020801	1,474,141	30,664	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,037,773	44,136,795	0.023513	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,464,074	120,901,298	0.012110	4,228,651	51,209	73.00	
73.01	07301	SPECIALTY PHARMACY	0	0	0.000000	0	0	73.01	
74.00	07400	RENAL DIALYSIS	22,654	6,064,046	0.003736	144,696	541	74.00	
76.00	03330	ENDOSCOPY	687,556	30,058,909	0.022874	264,639	6,053	76.00	
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.01	
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.02	
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.03	
76.04	03953	WOUND CARE	183,027	4,704,161	0.038907	61,917	2,409	76.04	
76.06	03954	IMAGING CENTER	1,024,209	58,112,435	0.017625	0	0	76.06	
76.07	03955	BREAST DIAGNOSTIC CENTER	571,326	29,811,164	0.019165	0	0	76.07	
<b>OUTPATIENT SERVICE COST CENTERS</b>									
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00	
90.01	04950	INFUSION CENTER	86,887	3,302,119	0.026312	0	0	90.01	
90.26	04975	SPINE CENTER	4,292	485,887	0.008833	0	0	90.26	
91.00	09100	EMERGENCY	1,227,310	181,995,890	0.006744	1,964,462	13,248	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	801,926	11,958,311	0.067060	372,382	24,972	92.00	
200.00		Total (lines 50 through 199)	20,444,868	1,295,917,136		24,662,742	344,821	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Prepared: 5/30/2022 2:39 pm
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Cost Center Description		Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
		1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	35.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	200.00
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
		4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	69,450	0.00	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	6,930	0.00	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	13,920	0.00	35.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,172	0.00	40.00
43.00	04300	NURSERY	0	0	7,863	0.00	43.00
200.00		Total (lines 30 through 199)	0	0	102,335		200.00
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
		9.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0				31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0				35.00
40.00	04000	SUBPROVIDER - IPF	0				40.00
43.00	04300	NURSERY	0				43.00
200.00		Total (lines 30 through 199)	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/30/2022 2:39 pm
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Cost Center Description	Title XIX			Hospital		Allied Health Post-Stepdown Adjustments	Allied Health PPS	
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program					
	1.00	2A	2.00	3A	3.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	SPECIALTY PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04	03953	WOUND CARE	0	0	0	0	0	76.04
76.06	03954	IMAGING CENTER	0	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	0	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	INFUSION CENTER	0	0	0	0	0	90.01
90.26	04975	SPI NE CENTER	0	0	0	0	0	90.26
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	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: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/30/2022 2:39 pm
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Title XIX		Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
				Hospital	PPS	
	4.00	5.00	6.00	Total Charges (from Wkst. C, Part I, col. 8)	7.00	8.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	241,411,841	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	41,078,473	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	25,543,697	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	41,729,784	0.000000	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	42,843,104	0.000000	55.00
57.00 05700 CT SCAN	0	0	0	80,377,004	0.000000	57.00
58.00 05800 MRI	0	0	0	28,984,229	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	4,526,842	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	135,435,346	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	1,313,965	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	36,633,886	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	25,033,802	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	7,469,870	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	2,305,044	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	9,585,209	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	14,758,041	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	65,355,984	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	44,136,795	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	120,901,298	0.000000	73.00
73.01 07301 SPECIALTY PHARMACY	0	0	0	0	0.000000	73.01
74.00 07400 RENAL DIALYSIS	0	0	0	6,064,046	0.000000	74.00
76.00 03330 ENDOSCOPY	0	0	0	30,058,909	0.000000	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.03
76.04 03953 WOUND CARE	0	0	0	4,704,161	0.000000	76.04
76.06 03954 IMAGING CENTER	0	0	0	58,112,435	0.000000	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0	0	29,811,164	0.000000	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0.000000	90.00
90.01 04950 INFUSION CENTER	0	0	0	3,302,119	0.000000	90.01
90.26 04975 SPINE CENTER	0	0	0	485,887	0.000000	90.26
91.00 09100 EMERGENCY	0	0	0	181,995,890	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	11,958,311	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	0	1,295,917,136		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/30/2022 2:39 pm
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Cost Center Description		Title XIX			Hospital		PPS
		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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	3,286,839	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	542,668	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	525,112	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	733,241	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	493,072	0	0	0	55.00
57.00	05700 CT SCAN	0.000000	1,353,120	0	0	0	57.00
58.00	05800 MRI	0.000000	344,863	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	269,424	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	4,695,577	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	53,667	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	2,919,084	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	143,105	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	228,561	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	106,529	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	385,297	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	71,695	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,474,141	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	4,228,651	0	0	0	73.00
73.01	07301 SPECIALTY PHARMACY	0.000000	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.000000	144,696	0	0	0	74.00
76.00	03330 ENDOSCOPY	0.000000	264,639	0	0	0	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.03
76.04	03953 WOUND CARE	0.000000	61,917	0	0	0	76.04
76.06	03954 IMAGING CENTER	0.000000	0	0	0	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.000000	0	0	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 INFUSION CENTER	0.000000	0	0	0	0	90.01
90.26	04975 SPINE CENTER	0.000000	0	0	0	0	90.26
91.00	09100 EMERGENCY	0.000000	1,964,462	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	372,382	0	0	0	92.00
200.00	Total (lines 50 through 199)		24,662,742	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/30/2022 2:39 pm
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.112906	0	1,425,015	0	0
51.00	05100 RECOVERY ROOM	0.159100	0	315,357	0	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.449912	0	0	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.180231	0	790,930	0	0
55.00	05500 RADIOLOGY-THERAPEUTIC	0.095719	0	366,440	0	0
57.00	05700 CT SCAN	0.043418	0	2,220,433	0	0
58.00	05800 MRI	0.114495	0	232,244	0	0
59.00	05900 CARDIAC CATHETERIZATION	0.050942	0	0	0	0
60.00	06000 LABORATORY	0.118520	0	1,663,286	0	0
64.00	06400 INTRAVENOUS THERAPY	1.196731	0	54	0	0
65.00	06500 RESPIRATORY THERAPY	0.212738	0	56,418	0	0
66.00	06600 PHYSICAL THERAPY	0.389352	0	144,205	0	0
67.00	06700 OCCUPATIONAL THERAPY	0.362070	0	55,777	0	0
68.00	06800 SPEECH PATHOLOGY	0.239349	0	39,713	0	0
69.00	06900 ELECTROCARDIOLOGY	0.067896	0	21,267	0	0
70.00	07000 ELECTROENCEPHALOGRAPHY	0.216099	0	147,075	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.362272	0	273,685	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.409323	0	0	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.257049	0	710,939	0	0
73.01	07301 SPECIALTY PHARMACY	0.000000	0	0	0	0
74.00	07400 RENAL DIALYSIS	0.253324	0	0	0	0
76.00	03330 ENDOSCOPY	0.147226	0	311,253	0	0
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0
76.04	03953 WOUND CARE	0.346746	0	60,466	0	0
76.06	03954 IMAGING CENTER	0.092906	0	407,218	0	0
76.07	03955 BREAST DIAGNOSTIC CENTER	0.485911	0	194,187	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0.000000	0	0	0	0
90.01	04950 INFUSION CENTER	0.088554	0	501	0	0
90.26	04975 SPINE CENTER	0.668546	0	0	0	0
91.00	09100 EMERGENCY	0.096313	0	7,592,243	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.849389	0	5,511	0	0
200.00	Subtotal (see instructions)		0	17,034,217	0	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00	Net Charges (line 200 - line 201)		0	17,034,217	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/30/2022 2:39 pm
	Title XIX	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	160,893	0		50.00
51.00 05100 RECOVERY ROOM	50,173	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	142,550	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	35,075	0		55.00
57.00 05700 CT SCAN	96,407	0		57.00
58.00 05800 MRI	26,591	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	197,133	0		60.00
64.00 06400 INTRAVENOUS THERAPY	65	0		64.00
65.00 06500 RESPIRATORY THERAPY	12,002	0		65.00
66.00 06600 PHYSICAL THERAPY	56,147	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	20,195	0		67.00
68.00 06800 SPEECH PATHOLOGY	9,505	0		68.00
69.00 06900 ELECTROCARDIOLOGY	1,444	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	31,783	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	99,148	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	182,746	0		73.00
73.01 07301 SPECIALTY PHARMACY	0	0		73.01
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03330 ENDOSCOPY	45,825	0		76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.03
76.04 03953 WOUND CARE	20,966	0		76.04
76.06 03954 IMAGING CENTER	37,833	0		76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	94,358	0		76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
90.01 04950 INFUSION CENTER	44	0		90.01
90.26 04975 SPINE CENTER	0	0		90.26
91.00 09100 EMERGENCY	731,232	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4,681	0		92.00
200.00 Subtotal (see instructions)	2,056,796	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	2,056,796	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/30/2022 2:39 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		69,450	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		69,450	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)		62,610	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		15,502	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		103,131,979	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		103,131,979	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		103,131,979	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,484.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		23,020,160	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)		23,020,160	41.00



COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/30/2022 2:39 pm
Title XVIII				Hospital	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	13,960,698	6,930	2,014.53	1,771	3,567,733	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 NEONATAL INTENSIVE CARE UNIT	20,513,861	13,920	1,473.70	0	0	47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					28,162,604	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					54,750,497	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)					2,197,794	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,276,962	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					4,474,756	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					50,275,741	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)					6,840	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,484.98	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					10,157,263	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/30/2022 2:39 pm	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	8,142,381	103,131,979	0.078951	10,157,263	801,926	90.00
91.00	Nursing Program cost	0	103,131,979	0.000000	10,157,263	0	91.00
92.00	Allied health cost	0	103,131,979	0.000000	10,157,263	0	92.00
93.00	All other Medical Education	0	103,131,979	0.000000	10,157,263	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/30/2022 2:39 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,172	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,172	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,172	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,866	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,748,643	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,748,643	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		4,748,643	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,138.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,123,919	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,123,919	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1		
				Component CCN: 15-S169		Date/Time Prepared: 5/30/2022 2:39 pm		
				Title XVIII	Subprovider - IPF	PPS		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)			
	1.00	2.00	3.00	4.00	5.00			
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00	
<b>Intensive Care Type Inpatient Hospital Units</b>								
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 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0		47.00	
<b>Cost Center Description</b>								
					1.00			
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						229,057		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						2,352,976		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>								
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						126,067		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						11,909		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						137,976		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						2,215,000		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>								
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>								
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>								
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>								
87.00 Total observation bed days (see instructions)						0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169 Component CCN: 15-S169		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/30/2022 2:39 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	281,869	4,748,643	0.059358	0	0	90.00
91.00	Nursing Program cost	0	4,748,643	0.000000	0	0	91.00
92.00	Allied health cost	0	4,748,643	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,748,643	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/30/2022 2:39 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		69,450	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		69,450	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)		62,610	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,232	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)		7,863	15.00
16.00	Nursery days (title V or XIX only)		3,254	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		104,087,807	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		104,087,807	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		104,087,807	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,498.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,345,188	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,345,188	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/30/2022 2:39 pm
				Title XIX	Hospital	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)	5,269,410	7,863	670.15	3,254	2,180,668	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	13,960,698	6,930	2,014.53	2,067	4,164,034	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 NEONATAL INTENSIVE CARE UNIT	20,513,861	13,920	1,473.70	0	0	47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,655,971	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					14,345,861	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)					930,180	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					344,821	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,275,001	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					13,070,860	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)					6,840	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,498.74	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					10,251,382	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/30/2022 2:39 pm	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	8,142,381	104,087,807	0.078226	10,251,382	801,925	90.00
91.00	Nursing Program cost	0	104,087,807	0.000000	10,251,382	0	91.00
92.00	Allied health cost	0	104,087,807	0.000000	10,251,382	0	92.00
93.00	All other Medical Education	0	104,087,807	0.000000	10,251,382	0	93.00



INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/30/2022 2:39 pm	
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		35,567,759		30.00
31.00	03100 INTENSIVE CARE UNIT		8,277,234		31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		0		35.00
40.00	04000 SUBPROVIDER - I/PF		0		40.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.112827	40,193,967	4,534,965	50.00
51.00	05100 RECOVERY ROOM	0.159100	5,118,114	814,292	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.449912	46,798	21,055	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.180231	3,057,293	551,019	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.095719	4,915,807	470,536	55.00
57.00	05700 CT SCAN	0.043418	8,488,678	368,561	57.00
58.00	05800 MRI	0.114495	1,515,129	173,475	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.050942	204,456	10,415	59.00
60.00	06000 LABORATORY	0.118520	23,717,235	2,810,967	60.00
64.00	06400 INTRAVENOUS THERAPY	1.196731	257,903	308,641	64.00
65.00	06500 RESPIRATORY THERAPY	0.212738	6,821,761	1,451,248	65.00
66.00	06600 PHYSICAL THERAPY	0.386483	1,628,163	629,257	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.362070	1,253,402	453,819	67.00
68.00	06800 SPEECH PATHOLOGY	0.239349	392,098	93,848	68.00
69.00	06900 ELECTROCARDIOLOGY	0.067896	3,977,104	270,029	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.216099	276,651	59,784	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.362272	7,759,087	2,810,900	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.409323	9,432,560	3,860,964	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.257049	20,894,365	5,370,876	73.00
73.01	07301 SPECIALTY PHARMACY	0.000000	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.253324	1,652,735	418,677	74.00
76.00	03330 ENDOSCOPY	0.147226	2,198,555	323,684	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.03
76.04	03953 WOUND CARE	0.346746	296,587	102,840	76.04
76.06	03954 IMAGING CENTER	0.092906	32,139	2,986	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.485911	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	04950 INFUSION CENTER	0.088554	0	0	90.01
90.26	04975 SPINE CENTER	0.668546	0	0	90.26
91.00	09100 EMERGENCY	0.095810	12,609,617	1,208,127	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.849389	1,226,339	1,041,639	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		157,966,543	28,162,604	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		157,966,543		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/30/2022 2:39 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY		4,474,923	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.112827	4,590	518 50.00
51.00	05100	RECOVERY ROOM	0.159100	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.449912	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180231	21,259	3,832 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.095719	0	0 55.00
57.00	05700	CT SCAN	0.043418	58,939	2,559 57.00
58.00	05800	MRI	0.114495	11,329	1,297 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.050942	0	0 59.00
60.00	06000	LABORATORY	0.118520	596,721	70,723 60.00
64.00	06400	INTRAVENOUS THERAPY	1.196731	3,255	3,895 64.00
65.00	06500	RESPIRATORY THERAPY	0.212738	5,568	1,185 65.00
66.00	06600	PHYSICAL THERAPY	0.386483	27,835	10,758 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.362070	24,417	8,841 67.00
68.00	06800	SPEECH PATHOLOGY	0.239349	5,184	1,241 68.00
69.00	06900	ELECTROCARDIOLOGY	0.067896	21,525	1,461 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.216099	5,614	1,213 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.362272	511	185 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.409323	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257049	384,857	98,927 73.00
73.01	07301	SPECIALTY PHARMACY	0.000000	0	0 73.01
74.00	07400	RENAL DIALYSIS	0.253324	0	0 74.00
76.00	03330	ENDOSCOPY	0.147226	0	0 76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0 76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0 76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0 76.03
76.04	03953	WOUND CARE	0.346746	0	0 76.04
76.06	03954	IMAGING CENTER	0.092906	0	0 76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.485911	0	0 76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	0 90.00
90.01	04950	INFUSION CENTER	0.088554	0	0 90.01
90.26	04975	SPI NE CENTER	0.668546	0	0 90.26
91.00	09100	EMERGENCY	0.095810	234,029	22,422 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.849389	0	0 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,405,633	229,057 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		1,405,633	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3	
		Title XIX	Hospital	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		9,999,009	30.00
31.00	03100	INTENSIVE CARE UNIT		2,088,162	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		17,273,423	35.00
40.00	04000	SUBPROVIDER - IPF		401,594	40.00
43.00	04300	NURSERY		1,817,388	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.112906	3,286,839	371,104 50.00
51.00	05100	RECOVERY ROOM	0.159100	542,668	86,338 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.449912	525,112	236,254 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180231	733,241	132,153 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.095719	493,072	47,196 55.00
57.00	05700	CT SCAN	0.043418	1,353,120	58,750 57.00
58.00	05800	MRI	0.114495	344,863	39,485 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.050942	269,424	13,725 59.00
60.00	06000	LABORATORY	0.118520	4,695,577	556,520 60.00
64.00	06400	INTRAVENOUS THERAPY	1.196731	53,667	64,225 64.00
65.00	06500	RESPIRATORY THERAPY	0.212738	2,919,084	621,000 65.00
66.00	06600	PHYSICAL THERAPY	0.389352	143,105	55,718 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.362070	228,561	82,755 67.00
68.00	06800	SPEECH PATHOLOGY	0.239349	106,529	25,498 68.00
69.00	06900	ELECTROCARDIOLOGY	0.067896	385,297	26,160 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.216099	71,695	15,493 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.362272	1,474,141	534,040 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.409323	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257049	4,228,651	1,086,971 73.00
73.01	07301	SPECIALTY PHARMACY	0.000000	0	0 73.01
74.00	07400	RENAL DIALYSIS	0.253324	144,696	36,655 74.00
76.00	03330	ENDOSCOPY	0.147226	264,639	38,962 76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0 76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0 76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0 76.03
76.04	03953	WOUND CARE	0.346746	61,917	21,469 76.04
76.06	03954	IMAGING CENTER	0.092906	0	0 76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.485911	0	0 76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	0 90.00
90.01	04950	INFUSION CENTER	0.088554	0	0 90.01
90.26	04975	SPINE CENTER	0.668546	0	0 90.26
91.00	09100	EMERGENCY	0.096313	1,964,462	189,203 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.849389	372,382	316,297 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		24,662,742	4,655,971 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		24,662,742	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/30/2022 2:39 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		26,817,269	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		8,648,353	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		670,313	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		204,197	2.04
3.00	Managed Care Simulated Payments		27,942,123	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		290.85	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		4.76	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		4.76	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		4.29	10.00
11.00	FTE count for residents in dental and podiatric programs.		2.77	11.00
12.00	Current year allowable FTE (see instructions)		7.06	12.00
13.00	Total allowable FTE count for the prior year.		6.92	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		6.14	14.00
15.00	Sum of lines 12 through 14 divided by 3.		6.71	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		6.71	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.023070	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.023509	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.023070	21.00
22.00	IME payment adjustment (see instructions)		444,313	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		350,059	22.01
<b>Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		-0.47	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		444,313	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		350,059	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.37	30.00
31.00	Percentage of Medicaid patient days (see instructions)		36.12	31.00
32.00	Sum of lines 30 and 31		40.49	32.00
33.00	Allowable disproportionate share percentage (see instructions)		22.62	33.00
34.00	Disproportionate share adjustment (see instructions)		2,005,581	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/30/2022 2:39 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>Uncompensated Care Adjustment</b>				
35.00	Total uncompensated care amount (see instructions)	8,290,014,521	7,192,008,710	35.00
35.01	Factor 3 (see instructions)	0.000145077	0.000277862	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,202,694	1,998,388	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	899,549	503,704	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,403,253		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>				
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	40,193,279		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
		<b>Amount</b>		
		<b>1.00</b>		
49.00	Total payment for inpatient operating costs (see instructions)		40,543,338	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,105,624	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		187,388	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		499,429	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		44,335,779	59.00
60.00	Primary payer payments		4,192	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		44,331,587	61.00
62.00	Deductibles billed to program beneficiaries		3,393,000	62.00
63.00	Coinurance billed to program beneficiaries		155,021	63.00
64.00	Allowable bad debts (see instructions)		114,512	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		74,433	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		13,956	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		40,857,999	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-94,656	70.93
70.94	HRR adjustment amount (see instructions)		-229,852	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/30/2022 2:39 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			425,159	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			40,108,332	71.00
71.01	Sequestration adjustment (see instructions)			0	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			0	71.03
72.00	Interim payments			39,210,310	72.00
72.01	Interim payments-PARHM				72.01
73.00	Tentative settlement (for contractor use only)			0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)				73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			898,022	74.00
74.01	Balance due provider/program-PARHM (see instructions)				74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			792,420	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)				90.00
91.00	Capital outlier from Wkst. L, Pt. 1, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. 11, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/30/2022 2:39 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		10,485	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		21,471,182	2.00
3.00	OPPS payments		16,144,882	3.00
4.00	Outlier payment (see instructions)		240,502	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)		10,485	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		40,791	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)		40,791	14.00
<b>Customary charges</b>				
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 charge basis 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)		40,791	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		30,306	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)		10,485	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)		16,385,384	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,847,741	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)		13,548,128	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		70,484	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)		13,618,612	30.00
31.00	Primary payer payments		4,784	31.00
32.00	Subtotal (line 30 minus line 31)		13,613,828	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		203,065	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		131,992	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		149,579	36.00
37.00	Subtotal (see instructions)		13,745,820	37.00
38.00	MSP-LCC reconciliation amount from PS&R		41	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)		13,745,779	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		13,927,960	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)		-182,181	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		11,198	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/30/2022 2:39 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			147 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			427 2.00
3.00	OPPS payments			428 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)			147 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			570 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)			570 14.00
<b>Customary charges</b>				
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 charge basis 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)			570 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			423 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)			147 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)			428 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			38 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)			537 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)			537 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			537 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			0 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (see instructions)			537 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)			537 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			528 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)			9 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
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 15-0169

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2022 2:39 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		39,210,310		13,927,960	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)		39,210,310		13,927,960	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		898,022		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		182,181	6.02	
7.00	Total Medicare program liability (see instructions)		40,108,332		13,745,779	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: 15-0169 Component CCN: 15-S169	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part I Date/Time Prepared: 5/30/2022 2:39 pm	
		Title XVIII	Subprovider - IPF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				
2.00	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		1,671,504		528
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)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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)		1,671,504		528
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		2,754		9
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		1,674,258		537
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/30/2022 2:39 pm
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
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
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial /interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part II Date/Time Prepared: 5/30/2022 2:39 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,859,592 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			11.430137 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$ .			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,859,592 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,859,592 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,859,592 18.00
19.00	Deductibles			136,148 19.00
20.00	Subtotal (line 18 minus line 19)			1,723,444 20.00
21.00	Coinsurance			51,940 21.00
22.00	Subtotal (line 20 minus line 21)			1,671,504 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			4,237 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			2,754 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			2,892 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,674,258 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.98	Recovery of accelerated depreciation.			0 30.98
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,674,258 31.00
31.01	Sequestration adjustment (see instructions)			0 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			1,671,504 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			2,754 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			2,013 35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00
<b>FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE</b>				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000 99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.000000 99.01

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 5/30/2022 2:39 pm
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Title XVIII		Hospital	PPS
			1.00

COMPUTATION OF TOTAL DIRECT GME AMOUNT			
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.		0.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)		0.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA		0.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)		0.00
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))		4.76
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)		0.00
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)		0.00
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)		4.76
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)		4.29
7.00	Enter the lesser of line 5 or line 6		4.29

		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	1.30	2.99	4.29	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	1.30	2.99	4.29	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		2.77		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		2.77		10.01
11.00	Total weighted FTE count	1.30	5.76		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.87	6.06		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	1.49	4.65		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	1.22	5.49		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	1.22	5.49		17.00
18.00	Per resident amount	101,580.29	101,580.29		18.00
19.00	Approved amount for resident costs	123,928	557,676	681,604	19.00

		Total			
		1.00			
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			681,604	25.00

		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	19,139	15,280		26.00
27.00	Total Inpatient Days (see instructions)	89,332	89,332		27.00
28.00	Ratio of inpatient days to total inpatient days	0.214246	0.171047		28.00
29.00	Program direct GME amount	146,031	116,586	262,617	29.00
29.01	Percent reduction for MA DGME		4.07		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		4,745	4,745	30.00
31.00	Net Program direct GME amount			257,872	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 5/30/2022 2:39 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)</b>				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		6,064,046	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
<b>APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY</b>				
<b>Part A Reasonable Cost</b>				
37.00	Reasonable cost (see instructions)		57,103,473	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		4,192	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		57,099,281	41.00
<b>Part B Reasonable Cost</b>				
42.00	Reasonable cost (see instructions)		21,482,241	42.00
43.00	Primary payer payments (see instructions)		4,784	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		21,477,457	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		78,576,738	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.726669	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.273331	47.00
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48.00	Total program GME payment (line 31)		257,872	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		187,388	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		70,484	50.00

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

Provider CCN: 15-0169

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

Worksheet G

Date/Time Prepared:  
5/30/2022 2:39 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	8,600	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	334,992,826	0	0	0	4.00
5.00	Other receivable	-245,455,908	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	1,222,378	0	0	0	6.00
7.00	Inventory	5,379,398	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	4,200	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)	96,151,494	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	2,705,851	0	0	0	12.00
13.00	Land improvements	4,358,832	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	326,057,951	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	3,525,194	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	125,865,939	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	19,930	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	-263,390,909	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	316,270	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	199,459,058	0	0	0	30.00
<b>OTHER ASSETS</b>						
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	1,234,960,268	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,234,960,268	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	1,530,570,820	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	1,267,479	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	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	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	29,492,970	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	30,760,449	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
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	3,700,336	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,700,336	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	34,460,785	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	1,496,110,035	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	1,496,110,035	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	1,530,570,820	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0169

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

Worksheet G-1

Date/Time Prepared:  
5/30/2022 2:39 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		1,376,840,494		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		119,269,541			2.00
3.00	Total (sum of line 1 and line 2)		1,496,110,035		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		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)		1,496,110,035		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		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)		1,496,110,035		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: 15-0169

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/30/2022 2:39 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	195,901,847		195,901,847	1.00
2.00	SUBPROVIDER - IPF	10,032,532		10,032,532	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)	205,934,379		205,934,379	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	32,529,183		32,529,183	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	NEONATAL INTENSIVE CARE UNIT	126,941,349		126,941,349	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	159,470,532		159,470,532	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	365,404,911		365,404,911	17.00
18.00	Ancillary services	644,083,646	732,335,268	1,376,418,914	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	787,608	787,608	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,009,488,557	733,122,876	1,742,611,433	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		431,915,799		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)		431,915,799		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0169

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

Worksheet G-3

Date/Time Prepared:  
5/30/2022 2:39 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,742,611,433	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,195,636,474	2.00
3.00	Net patient revenues (line 1 minus line 2)	546,974,959	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	431,915,799	4.00
5.00	Net income from service to patients (line 3 minus line 4)	115,059,160	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	769,776	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	2,088,419	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	24,000	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC ALL OTHER	1,328,186	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	4,210,381	25.00
26.00	Total (line 5 plus line 25)	119,269,541	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	119,269,541	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0169	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 5/30/2022 2:39 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		2,722,803	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		128,511	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		239.73	3.00
4.00	Number of interns & residents (see instructions)		6.71	4.00
5.00	Indirect medical education percentage (see instructions)		0.79	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		21,510	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		4.37	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		36.12	8.00
9.00	Sum of lines 7 and 8		40.49	9.00
10.00	Allowable disproportionate share percentage (see instructions)		8.55	10.00
11.00	Disproportionate share adjustment (see instructions)		232,800	11.00
12.00	Total prospective capital payments (see instructions)		3,105,624	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00