

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: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/26/2022 9:38 am
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**PART I - COST REPORT STATUS**

Provider use only 1.  Electronically prepared cost report Date: 5/26/2022 Time: 9:38 am  
 2.  Manually prepared cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.

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

**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 GOOD SAMARITAN HOSPITAL ( 15-0042 ) 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	<b>Matthew Schuckman</b>	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	Matthew Schuckman		2
3	Signatory Title	CFO		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	1,789,548	185,404	0	-391,193	1.00
2.00 Subprovider - IPF	0	110,818	9		176,862	2.00
3.00 Subprovider - IRF	0	75,798	18		-5,619	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	1,976,164	185,431	0	-219,950	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: 15-0042			Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 9:38 am				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 520 SOUTH 7TH STREET			PO Box:						1.00	
2.00	City: VINCENNES			State: IN		Zip Code: 47591		County: KNOX		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		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		GOOD SAMARITAN HOSPITAL	150042	99915	1	07/01/1966	N	P	0	3.00
4.00	Subprovider - IPF		GOOD SAMARITAN HOSPITAL	15S042	99915	4	01/01/1984	N	P	0	4.00
5.00	Subprovider - IRF		GOOD SAMARITAN - REHAB	15T042	99915	5	01/01/2001	N	P	0	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		GOOD SAMARITAN HOME CENTER	157432	99915		06/27/1995	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice		GOOD SAMARITAN LINCOLN TRAIL HOSPICE	151526	99915		01/01/1984				14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2021	12/31/2021		20.00	
21.00	Type of Control (see instructions)						9			21.00	
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	N		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		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		22.04		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N		23.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0042			Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 9:38 am		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	461	597	0	576	1,633	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	53	99	0	31	133		25.00	
						Urban/Rural	S	Date of Geogr	
						1.00		2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:		Ending:	
						1.00		2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					1		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.					01/01/2021	12/31/2021	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	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
<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

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		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.	Y	Y			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.01	1		60.01	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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	
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
<b>Teaching Hospitals that Claim Residents in Nonprovider Settings</b>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00

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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	8.53	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)	INTERNAL MEDICINE	1400	0.00	16.18	0.000000	67.00

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		1.00	2.00	3.00		
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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	Y	3		71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y				75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0		76.00
					1.00	
<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.		N			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	Y			91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N			92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N			93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N			94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00			95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N			96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00			97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y			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.	N	Y			98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y			98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N			98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N			98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y			98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y			98.06
<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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 9:38 am
			V 1.00	XIX 2.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N	
		Physical 1.00	Occupational 2.00	Speech 3.00
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
				Respiratory 4.00
				1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	
			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	
			1.00	2.00
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	
			1.00	2.00
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		
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		
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	
		Premiums 1.00	Losses 2.00	Insurance 3.00
118.01	List amounts of malpractice premiums and paid losses:	484,744	0	0
			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	
119.00	DO NOT USE THIS LINE			
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
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	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		Y	5.00
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	
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.			
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.			
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.			
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.			
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.			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0042		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 9:38 am	
		1.00	2.00				
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						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	
		Name		County		State	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						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	
						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	



HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 9:38 am
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 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		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0042		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 9:38 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		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)	N					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				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	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.	Y					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)	Y	03/08/2022	Y	03/08/2022		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 9:38 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		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			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			Y	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<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.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<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.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				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.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			Y	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?			N	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.	KYLE		SMI TH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO, LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMI TH@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 9:38 am
		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		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: 15-0042

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/26/2022 9:38 am

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	69	25,185	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)		69	25,185	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	30	10,950	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		99	36,135	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	20	7,300		0	16.00
17.00 SUBPROVIDER - IRF	41.00	25	9,125		0	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	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			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)		144				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: 15-0042

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/26/2022 9:38 am

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)	5,049	461	10,896			1.00
2.00 HMO and other (see instructions)	2,821	2,806				2.00
3.00 HMO IPF Subprovider	90	1,836				3.00
4.00 HMO IRF Subprovider	130	263				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)	5,049	461	10,896			7.00
8.00 INTENSIVE CARE UNIT	2,552	0	5,425			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	942			13.00
14.00 Total (see instructions)	7,601	461	17,263	20.77	1,434.25	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	933	410	4,801	3.95	30.85	16.00
17.00 SUBPROVIDER - IRF	5,223	53	7,092	0.00	31.72	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	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	7.42	24.00
24.10 HOSPICE (non-distinct part)			465			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)				24.72	1,504.24	27.00
28.00 Observation Bed Days		564	3,195			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	414			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: 15-0042

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/26/2022 9:38 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,808	75	4,051	1.00
2.00	HMO and other (see instructions)			554	641		2.00
3.00	HMO IPF Subprovider				412		3.00
4.00	HMO IRF Subprovider				22		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,808	75	4,051	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	130	65	910	16.00
17.00	SUBPROVIDER - IRF	0.00	0	336	4	479	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					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: 15-0042

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/26/2022 9:38 am

	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	108,210,873	0	108,210,873	3,128,815.00	34.59
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		190,857	0	190,857	1,180.00	161.74
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		4,409,936	0	4,409,936	17,295.00	254.98
6.00	Non-physician-Part B for hospital-based RHC and FOHC 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)		2,186,999	0	2,186,999	39,779.71	54.98
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)		37,837,332	0	37,837,332	915,791.00	41.32
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		3,176,524	0	3,176,524	45,481.00	69.84
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		583,826	0	583,826	6,818.00	85.63
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		0	0	0	0.00	0.00
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)		20,671,328	0	20,671,328		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		9,077,461	0	9,077,461		
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		21,961	0	21,961		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		397,795	0	397,795		
24.00	Wage-related costs (RHC/FOHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
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: 15-0042

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/26/2022 9:38 am

	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	5,883,651	0	5,883,651	281,014.00	20.94	26.00
27.00	Administrative & General	7,206,764	0	7,206,764	191,414.00	37.65	27.00
28.00	Administrative & General under contract (see inst.)	1,104,719	0	1,104,719	5,558.00	198.76	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	2,314,574	0	2,314,574	93,798.00	24.68	30.00
31.00	Laundry & Linen Service	220,992	0	220,992	14,941.00	14.79	31.00
32.00	Housekeeping	2,043,150	0	2,043,150	123,817.00	16.50	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	1,732,758	-1,135,650	597,108	33,172.00	18.00	34.00
35.00	Dietary under contract (see instructions)	10,049	0	10,049	43.00	233.70	35.00
36.00	Cafeteria	0	1,135,650	1,135,650	63,091.00	18.00	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	2,288,533	0	2,288,533	57,320.00	39.93	38.00
39.00	Central Services and Supply	358,307	0	358,307	17,979.00	19.93	39.00
40.00	Pharmacy	2,911,308	0	2,911,308	68,750.00	42.35	40.00
41.00	Medical Records & Medical Records Library	3,617,256	0	3,617,256	123,957.00	29.18	41.00
42.00	Social Service	475,129	0	475,129	13,050.00	36.41	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0042

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/26/2022 9:38 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on 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)	102,728,706	0	102,728,706	3,077,341.29	33.38	1.00
2.00	Excluded area salaries (see instructions)	37,837,332	0	37,837,332	915,791.00	41.32	2.00
3.00	Subtotal salaries (line 1 minus line 2)	64,891,374	0	64,891,374	2,161,550.29	30.02	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,760,350	0	3,760,350	52,299.00	71.90	4.00
5.00	Subtotal wage-related costs (see inst.)	20,693,289	0	20,693,289	0.00	31.89	5.00
6.00	Total (sum of lines 3 thru 5)	89,345,013	0	89,345,013	2,213,849.29	40.36	6.00
7.00	Total overhead cost (see instructions)	30,167,190	0	30,167,190	1,087,904.00	27.73	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prepared: 5/26/2022 9:38 am
				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			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		4,692,079	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 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			0 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)		17,153,432	8.02
8.03	Health Insurance (Purchased)			0 8.03
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan		315,112	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		113,829	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)		286,821	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance		213,918	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		7,268,991	17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance		-5,504	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		50,244	22.00
23.00	Tuition Reimbursement		79,621	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		30,168,543	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: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part V Date/Time Prepared: 5/26/2022 9:38 am
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	3,176,524	30,168,543	1.00
2.00	Hospital	3,176,524	30,168,543	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	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			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-0042  
Hospice CCN: 15-1526

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

Worksheet S-9  
PARTS I THROUGH IV  
Date/Time Prepared:  
5/26/2022 9:38 am

		Hospice I						
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015</b>								
1.00	Hospice Continuous Home Care						1.00	
2.00	Hospice Routine Home Care						2.00	
3.00	Hospice Inpatient Respite Care						3.00	
4.00	Hospice General Inpatient Care						4.00	
5.00	Total Hospice Days						5.00	
<b>Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015</b>								
6.00	Number of patients receiving hospice care						6.00	
7.00	Total number of unduplicated Continuous Care hours billable to Medicare						7.00	
8.00	Average Length of Stay (line 5 / line 6)						8.00	
9.00	Unduplicated census count						9.00	

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
<b>PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015</b>						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	3,497	89	1,041	4,627	11.00
12.00	Hospice Inpatient Respite Care	12	0	3	15	12.00
13.00	Hospice General Inpatient Care	339	37	74	450	13.00
14.00	Total Hospice Days	3,848	126	1,118	5,092	14.00
<b>PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015</b>						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/26/2022 9:38 am
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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)		0.255593	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		15,658,088	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		93,412,666	6.00	
7.00	Medicaid cost (line 1 times line 6)		23,875,624	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)		8,217,536	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)		8,217,536	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)	4,834,153	1,409,331	6,243,484	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,235,576	1,409,331	2,644,907	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,235,576	1,409,331	2,644,907	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		11,016,650	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		457,120	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		703,262	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		10,313,388	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,882,172	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		5,527,079	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		13,744,615	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet A Date/Time Prepared: 5/26/2022 9:38 am
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		16,404,265	16,404,265	6,158,828	22,563,093	1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		95,144	95,144	0	95,144	2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	563,129	1,462,565	2,025,694	28,704,249	30,729,943	4.00
4.01 00401 COMMUNICATIONS	283,462	118,721	402,183	-117,830	284,353	4.01
4.02 00402 PURCHASING & RECEIVING	672,983	607,522	1,280,505	-296,274	984,231	4.02
4.03 00403 REGISTRATION	1,735,815	739,480	2,475,295	-683,280	1,792,015	4.03
4.04 00404 PATIENT ACCOUNTS	2,628,262	2,633,357	5,261,619	-967,882	4,293,737	4.04
5.00 00500 ADMIN STRATIVE & GENERAL	7,206,764	23,551,146	30,757,910	-2,356,228	28,401,682	5.00
7.00 00700 OPERATION OF PLANT	2,314,574	4,767,086	7,081,660	-717,235	6,364,425	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	220,992	198,649	419,641	-117,680	301,961	8.00
9.00 00900 HOUSEKEEPING	2,043,150	1,053,162	3,096,312	-807,093	2,289,219	9.00
10.00 01000 DIETARY	1,732,758	1,767,597	3,500,355	-2,497,841	1,002,514	10.00
11.00 01100 CAFETERIA	0	0	0	1,906,698	1,906,698	11.00
13.00 01300 NURSING ADMINISTRATION	2,288,533	1,832,569	4,121,102	-496,844	3,624,258	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	358,307	301,830	660,137	-99,208	560,929	14.00
15.00 01500 PHARMACY	2,911,308	17,669,628	20,580,936	-17,398,990	3,181,946	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	3,617,256	1,621,725	5,238,981	-1,157,566	4,081,415	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
17.01 01701 MENTAL HEALTH OH	475,129	385,793	860,922	-139,792	721,130	17.01
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	2,186,999	2,186,999	0	2,186,999	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	1,411,338	672,404	2,083,742	-302,845	1,780,897	22.00
23.00 02300 PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01 02301 PARAMED ED PRGM-LAB	240,212	87,898	328,110	-63,887	264,223	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	4,792,314	3,735,247	8,527,561	-935,671	7,591,890	30.00
31.00 03100 INTENSIVE CARE UNIT	3,272,273	2,496,807	5,769,080	-793,352	4,975,728	31.00
40.00 04000 SUBPROVIDER - I PF	2,052,405	630,617	2,683,022	-446,187	2,236,835	40.00
41.00 04100 SUBPROVIDER - I RF	2,034,132	933,821	2,967,953	-519,040	2,448,913	41.00
43.00 04300 NURSERY	338,753	116,835	455,588	-85,802	369,786	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	3,247,268	5,707,038	8,954,306	-3,258,793	5,695,513	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
51.01 05101 ENDOSCOPY	730,592	1,006,275	1,736,867	-418,405	1,318,462	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	1,291,929	425,769	1,717,698	-578,929	1,138,769	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	3,607,006	4,585,682	8,192,688	-1,999,983	6,192,705	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	2,710,338	1,926,261	4,636,599	-693,606	3,942,993	55.00
60.00 06000 LABORATORY	2,307,337	5,553,526	7,860,863	-680,711	7,180,152	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	2,491,029	1,945,870	4,436,899	-897,141	3,539,758	65.00
66.00 06600 PHYSICAL THERAPY	3,851,462	1,149,889	5,001,351	-985,748	4,015,603	66.00
69.00 06900 ELECTROCARDIOLOGY	5,030,178	3,537,154	8,567,332	-2,762,492	5,804,840	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01 07001 NEURODIAGNOSTICS	422,506	885,950	1,308,456	-90,310	1,218,146	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,812,175	3,812,175	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,550,584	3,550,584	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	16,640,044	16,640,044	73.00
75.00 07500 ASC (NON-DISTINCT PART)	1,025,093	2,158,466	3,183,559	-1,451,316	1,732,243	75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01 03951 INPATIENT DIALYSIS	0	479,527	479,527	-3,197	476,330	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	77,480	15,610	93,090	-14,368	78,722	90.00
90.01 04950 WOUND CLINIC	395,709	1,276,340	1,672,049	-608,087	1,063,962	90.01
91.00 09100 EMERGENCY	4,224,546	2,926,188	7,150,734	-974,988	6,175,746	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	93,968	81,980	175,948	-17,773	158,175	96.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE		5,754,829	5,754,829	-5,754,829	0	113.00
116.00 11600 HOSPICE	448,702	286,423	735,125	-114,362	620,763	116.00
118.00 11800 SUBTOTALS (SUM OF LINES 1 through 117)	75,148,992	125,773,644	200,922,636	8,467,013	209,389,649	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	21,890,755	14,509,606	36,400,361	-5,357,281	31,043,080	192.00
192.01 19201 FP PETERSBURG	232,381	275,412	507,793	-73,139	434,654	192.01
192.02 19202 PEDIATRICS	1,091,031	625,700	1,716,731	-334,812	1,381,919	192.02
192.03 19203 WASHINGTON PRIMARY CARE	1,368,298	592,237	1,960,535	-393,346	1,567,189	192.03
192.04 19204 FOHC	9,660	0	9,660	0	9,660	192.04
194.00 07950 COMMUNITY HEALTH SERVICES	101,264	59,974	161,238	-26,249	134,989	194.00
194.01 07960 CCBHC GRANTS	1,357,807	779,588	2,137,395	-383,383	1,754,012	194.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-0042		Period: From 01/01/2021 To 12/31/2021		Worksheet A Date/Time Prepared: 5/26/2022 9:38 am	
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)			
	1.00	2.00	3.00	4.00	5.00			
194.02 07952 MARKETING AND PUBLIC RELATIONS	235,800	659,280	895,080	-71,030	824,050	194.02		
194.03 07953 MH RESIDENTIAL	485,347	177,676	663,023	-125,442	537,581	194.03		
194.04 07954 UNUSED SPACE	0	0	0	0	0	194.04		
194.05 07955 MOB	0	41,971	41,971	0	41,971	194.05		
194.06 07956 FOUNDATION	0	0	0	0	0	194.06		
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07		
194.08 07958 INDUSTRIAL HEALTH	0	0	0	0	0	194.08		
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	6,289,538	2,312,014	8,601,552	-1,702,331	6,899,221	194.09		
200.00 TOTAL (SUM OF LINES 118 through 199)	108,210,873	145,807,102	254,017,975	0	254,017,975	200.00		



RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0042

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

Worksheet A  
Date/Time Prepared:  
5/26/2022 9:38 am

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	-1,602,212	20,960,881	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	95,144	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-890	30,729,053	4.00
4.01	00401	COMMUNICATIONS	-58,499	225,854	4.01
4.02	00402	PURCHASING & RECEIVING	-238,296	745,935	4.02
4.03	00403	REGISTRATION	0	1,792,015	4.03
4.04	00404	PATIENT ACCOUNTS	-65,051	4,228,686	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	-13,485,049	14,916,633	5.00
7.00	00700	OPERATION OF PLANT	-59,859	6,304,566	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-12,520	289,441	8.00
9.00	00900	HOUSEKEEPING	-31,500	2,257,719	9.00
10.00	01000	DIETARY	0	1,002,514	10.00
11.00	01100	CAFETERIA	-909,380	997,318	11.00
13.00	01300	NURSING ADMINISTRATION	-140,096	3,484,162	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	560,929	14.00
15.00	01500	PHARMACY	-8,042	3,173,904	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-48,741	4,032,674	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
17.01	01701	MENTAL HEALTH OH	-3,845	717,285	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	2,186,999	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	186,245	1,967,142	22.00
23.00	02300	PARAMED PRGM-RADIOLOGY	0	0	23.00
23.01	02301	PARAMED PRGM-LAB	-37,956	226,267	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	7,591,890	30.00
31.00	03100	INTENSIVE CARE UNIT	-236	4,975,492	31.00
40.00	04000	SUBPROVIDER - IPF	-258,395	1,978,440	40.00
41.00	04100	SUBPROVIDER - IRF	-272	2,448,641	41.00
43.00	04300	NURSERY	0	369,786	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-2,465,491	3,230,022	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
51.01	05101	ENDOSCOPY	-20,501	1,297,961	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	-600	1,138,169	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-13,612	6,179,093	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-1,126,990	2,816,003	55.00
60.00	06000	LABORATORY	-1,200	7,178,952	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	-1,061,827	2,477,931	65.00
66.00	06600	PHYSICAL THERAPY	-366	4,015,237	66.00
69.00	06900	ELECTROCARDIOLOGY	-3,285,379	2,519,461	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	-5,315	1,212,831	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,812,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,550,584	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-364,851	16,275,193	73.00
75.00	07500	ASC (NON-DISTINCT PART)	-124,565	1,607,678	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	-208,995	267,335	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	78,722	90.00
90.01	04950	WOUND CLINIC	-1,702	1,062,260	90.01
91.00	09100	EMERGENCY	-1,251,252	4,924,494	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	158,175	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	620,763	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-26,707,240	182,682,409	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	31,043,080	192.00
192.01	19201	FP PETERSBURG	0	434,654	192.01
192.02	19202	PEDIATRICS	0	1,381,919	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	1,567,189	192.03
192.04	19204	FQHC	0	9,660	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	134,989	194.00
194.01	07960	CCBHC GRANTS	0	1,754,012	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	824,050	194.02
194.03	07953	MH RESIDENTIAL	0	537,581	194.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0042

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

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Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
194.04	07954	UNUSED SPACE	0	0	194.04
194.05	07955	MOB	0	41,971	194.05
194.06	07956	FOUNDATION	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	6,899,221	194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	-26,707,240	227,310,735	200.00

RECLASSIFICATIONS

Provider CCN: 15-0042

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

Worksheet A-6

Date/Time Prepared:  
5/26/2022 9:38 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - DRUGS CHARGED TO PATIENTS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	16,640,044	1.00
			0	16,640,044	
<b>B - MEDICAL SUPPLIES CHARGED TO PATIENTS</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,812,175	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,550,584	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	50,223	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
			0	7,412,982	
<b>C - EMPLOYEE BENEFITS</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	28,739,517	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
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0.00	0	0	39.00

RECLASSIFICATIONS

Provider CCN: 15-0042

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		
40.00		0.00	0	0		40.00
41.00		0.00	0	0		41.00
42.00		0.00	0	0		42.00
43.00		0.00	0	0		43.00
44.00		0.00	0	0		44.00
45.00		0.00	0	0		45.00
46.00		0.00	0	0		46.00
	0		0	28,739,517		
<b>D - INTEREST EXPENSE</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,754,829		1.00
	0		0	5,754,829		
<b>E - INSURANCE EXPENSE</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	403,999		1.00
	0		0	403,999		
<b>F - DIETARY RECLASS</b>						
1.00	CAFETERIA	11.00	1,135,650	771,048		1.00
	0		1,135,650	771,048		
<b>G - OB RECLASS</b>						
1.00	ADULTS & PEDIATRICS	30.00	275,568	33,189		1.00
	0		275,568	33,189		
500.00	Grand Total: Increases		1,411,218	59,755,608		500.00

RECLASSIFICATIONS

Provider CCN: 15-0042

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

Worksheet A-6  
Date/Time Prepared:  
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		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>A - DRUGS CHARGED TO PATIENTS</b>							
1.00	PHARMACY	15.00	0	16,640,044	0		1.00
	O		0	16,640,044			
<b>B - MEDICAL SUPPLIES CHARGED TO PATIENTS</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35,268	0		1.00
2.00	PURCHASING & RECEIVING	4.02	0	142	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00		162	0		3.00
4.00	OPERATION OF PLANT	7.00		1,677	0		4.00
5.00	HOUSEKEEPING	9.00		29	0		5.00
6.00	NURSING ADMINISTRATION	13.00		5,622	0		6.00
7.00	PHARMACY	15.00		24,115	0		7.00
8.00	ADULTS & PEDIATRICS	30.00		92,406	0		8.00
9.00	INTENSIVE CARE UNIT	31.00		45,318	0		9.00
10.00	SUBPROVIDER - IPF	40.00		406	0		10.00
11.00	SUBPROVIDER - IRF	41.00		2,418	0		11.00
12.00	NURSERY	43.00		6,716	0		12.00
13.00	OPERATING ROOM	50.00		2,416,196	0		13.00
14.00	ENDOSCOPY	51.01		214,514	0		14.00
15.00	DELIVERY ROOM & LABOR ROOM	52.00		20,242	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00		960,650	0		16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00		8,851	0		17.00
18.00	LABORATORY	60.00		3,597	0		18.00
19.00	RESPIRATORY THERAPY	65.00		197,949	0		19.00
20.00	PHYSICAL THERAPY	66.00		5,638	0		20.00
21.00	ELECTROCARDIOLOGY	69.00		1,601,489	0		21.00
22.00	NEURODIAGNOSTICS	70.01		1,569	0		22.00
23.00	ASC (NON-DISTINCT PART)	75.00		1,143,217	0		23.00
24.00	INPATIENT DIALYSIS	76.01		3,197	0		24.00
25.00	CLINIC	90.00		17	0		25.00
26.00	WOUND CLINIC	90.01		529,977	0		26.00
27.00	EMERGENCY	91.00		91,600	0		27.00
	O		0	7,412,982			
<b>C - EMPLOYEE BENEFITS</b>							
1.00	COMMUNICATIONS	4.01		117,830	0		1.00
2.00	PURCHASING & RECEIVING	4.02		296,132	0		2.00
3.00	REGISTRATION	4.03		683,280	0		3.00
4.00	PATIENT ACCOUNTS	4.04		967,882	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00		1,952,067	0		5.00
6.00	OPERATION OF PLANT	7.00		715,558	0		6.00
7.00	LAUNDRY & LINEN SERVICE	8.00		117,680	0		7.00
8.00	HOUSEKEEPING	9.00		807,064	0		8.00
9.00	DIETARY	10.00		591,143	0		9.00
10.00	NURSING ADMINISTRATION	13.00		491,222	0		10.00
11.00	CENTRAL SERVICES & SUPPLY	14.00		149,431	0		11.00
12.00	PHARMACY	15.00		734,831	0		12.00
13.00	MEDICAL RECORDS & LIBRARY	16.00		1,157,566	0		13.00
14.00	MENTAL HEALTH OH	17.01		139,792	0		14.00
15.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00		302,845	0		15.00
16.00	PARAMED ED PRGM-LAB	23.01		63,887	0		16.00
17.00	ADULTS & PEDIATRICS	30.00		1,152,022	0		17.00
18.00	INTENSIVE CARE UNIT	31.00		748,034	0		18.00
19.00	SUBPROVIDER - IPF	40.00		445,781	0		19.00
20.00	SUBPROVIDER - IRF	41.00		516,622	0		20.00
21.00	NURSERY	43.00		79,086	0		21.00
22.00	OPERATING ROOM	50.00		842,597	0		22.00
23.00	ENDOSCOPY	51.01		203,891	0		23.00
24.00	DELIVERY ROOM & LABOR ROOM	52.00		249,930	0		24.00
25.00	RADIOLOGY-DIAGNOSTIC	54.00		1,039,333	0		25.00
26.00	RADIOLOGY-THERAPEUTIC	55.00		684,755	0		26.00
27.00	LABORATORY	60.00		677,114	0		27.00
28.00	RESPIRATORY THERAPY	65.00		699,192	0		28.00
29.00	PHYSICAL THERAPY	66.00		980,110	0		29.00
30.00	ELECTROCARDIOLOGY	69.00		1,161,003	0		30.00
31.00	NEURODIAGNOSTICS	70.01		88,741	0		31.00
32.00	ASC (NON-DISTINCT PART)	75.00		308,099	0		32.00
33.00	CLINIC	90.00		14,351	0		33.00
34.00	WOUND CLINIC	90.01		78,110	0		34.00
35.00	EMERGENCY	91.00		883,388	0		35.00
36.00	DURABLE MEDICAL EQUIP-RENTED	96.00		17,773	0		36.00
37.00	HOSPICE	116.00		114,362	0		37.00
38.00	PHYSICIANS' PRIVATE OFFICES	192.00		5,357,281	0		38.00
39.00	FP PETERSBURG	192.01		73,139	0		39.00
40.00	PEDIATRICS	192.02		334,812	0		40.00

RECLASSIFICATIONS

Provider CCN: 15-0042

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

Worksheet A-6

Date/Time Prepared:  
5/26/2022 9:38 am

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
41.00	WASHINGTON PRIMARY CARE	192.03		393,346	0		41.00
42.00	COMMUNITY HEALTH SERVICES	194.00		26,249	0		42.00
43.00	CCBHC GRANTS	194.01		383,383	0		43.00
44.00	MARKETING AND PUBLIC RELATIONS	194.02		71,030	0		44.00
45.00	MH RESIDENTIAL	194.03		125,442	0		45.00
46.00	COMMUNITY MENTAL HEALTH CENTER	194.09		1,702,331	0		46.00
			0	28,739,517			
D - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	5,754,829	11		1.00
			0	5,754,829			
E - INSURANCE EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	403,999	12		1.00
			0	403,999			
F - DIETARY RECLASS							
1.00	DIETARY	10.00	1,135,650	771,048	0		1.00
			1,135,650	771,048			
G - OB RECLASS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	275,568	33,189	0		1.00
			275,568	33,189			
500.00	Grand Total: Decreases		1,411,218	59,755,608			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0042

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/26/2022 9:38 am

		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	6,581,448	0	0	0	0	1.00
2.00	Land Improvements	10,692,230	34,368	0	34,368	0	2.00
3.00	Buildings and Fixtures	169,412,708	2,317,383	0	2,317,383	0	3.00
4.00	Building Improvements	510,867	4,559	0	4,559	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	222,593,629	2,009,694	0	2,009,694	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	409,790,882	4,366,004	0	4,366,004	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	409,790,882	4,366,004	0	4,366,004	0	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	6,581,448	0				1.00
2.00	Land Improvements	10,726,598	0				2.00
3.00	Buildings and Fixtures	171,730,091	0				3.00
4.00	Building Improvements	515,426	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	224,603,323	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	414,156,886	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	414,156,886	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0042

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	16,404,265	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	95,144	0	0	2.00
3.00	Total (sum of lines 1-2)	16,404,265	0	95,144	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	16,404,265				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	95,144				2.00
3.00	Total (sum of lines 1-2)	0	16,499,409				3.00



RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0042

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/26/2022 9:38 am

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	189,553,563	0	189,553,563	0.457685	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	224,603,323	0	224,603,323	0.542315	0	2.00
3.00	Total (sum of lines 1-2)	414,156,886	0	414,156,886	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	16,404,265	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	16,404,265	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	4,152,617	403,999	0	0	20,960,881	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	95,144	0	0	0	95,144	2.00
3.00	Total (sum of lines 1-2)	4,247,761	403,999	0	0	21,056,025	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0042

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

Worksheet A-8

Date/Time Prepared:  
5/26/2022 9:38 am

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.
			Cost Center	Line #	
			1.00	2.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,602,212	CAP REL COSTS-BLDG & FIXT	1.00	11 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0 2.00
3.00 Investment income - other (chapter 2)		0		0.00	0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-45,303	PURCHASING & RECEIVING	4.02	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)	B	-26,758	OPERATION OF PLANT	7.00	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	-9,624,314			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	0			0 12.00
13.00 Laundry and linen service		0		0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-290,773	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	B	-364,851	DRUGS CHARGED TO PATIENTS	73.00	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
19.01 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0 19.01
20.00 Vending machines	B	-25,785	CAFETERIA	11.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant		0		0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00	31.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0042

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

Worksheet A-8

Date/Time Prepared:  
5/26/2022 9:38 am

32.00	CAH HIT Adjustment for Depreciation and Interest	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	32.00
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
			0		0.00		0 32.00
33.00	MISC INCOME	B	-890	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.00
33.01	MISC INCOME	B	-192,993	PURCHASING & RECEIVING	4.02		0 33.01
33.02	MISC INCOME	B	-138	PATIENT ACCOUNTS	4.04		0 33.02
33.03	MISC INCOME	B	-896,615	ADMINISTRATIVE & GENERAL	5.00		0 33.03
33.04	MISC INCOME	B	-33,101	OPERATION OF PLANT	7.00		0 33.04
33.05	MISC INCOME	B	-12,520	LAUNDRY & LINEN SERVICE	8.00		0 33.05
33.06	MISC INCOME	B	-31,500	HOUSEKEEPING	9.00		0 33.06
33.07	MISC INCOME	B	-2,401	NURSING ADMINISTRATION	13.00		0 33.07
33.08	MISC INCOME	B	-120	PHARMACY	15.00		0 33.08
33.09	MISC INCOME	B	-48,741	MEDICAL RECORDS & LIBRARY	16.00		0 33.09
33.10	MISC INCOME	B	-37,956	PARAMED ED PRGM-LAB	23.01		0 33.10
33.11	MISC INCOME	B	-236	INTENSIVE CARE UNIT	31.00		0 33.11
33.12	MISC INCOME	B	-24,881	OPERATING ROOM	50.00		0 33.12
33.13	MISC INCOME	B	-20,501	ENDOSCOPY	51.01		0 33.13
33.14	MISC INCOME	B	-600	DELIVERY ROOM & LABOR ROOM	52.00		0 33.14
33.15	MISC INCOME	B	-82,063	ELECTROCARDIOLOGY	69.00		0 33.15
33.16	MISC INCOME	B	-50,000	ASC (NON-DISTINCT PART)	75.00		0 33.16
33.17	MISC INCOME	B	-1,458	WOUND CLINIC	90.01		0 33.17
33.18	ADVERTISING	A	-1,023	ADMINISTRATIVE & GENERAL	5.00		0 33.18
33.19	ADVERTISING	A	-3,845	MENTAL HEALTH OH	17.01		0 33.19
33.20	ADVERTISING	A	-13,755	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00		0 33.20
33.21	ADVERTISING	A	-272	SUBPROVIDER - IRF	41.00		0 33.21
33.22	ADVERTISING	A	-366	PHYSICAL THERAPY	66.00		0 33.22
33.23	ADVERTISING	A	-879	ELECTROCARDIOLOGY	69.00		0 33.23
33.24	ADVERTISING	A	-244	WOUND CLINIC	90.01		0 33.24
33.25	PHYSICIAN BILLING COSTS	A	-64,913	PATIENT ACCOUNTS	4.04		0 33.25
33.26	2012 BOND ISSUE COSTS	A	45,855	ADMINISTRATIVE & GENERAL	5.00		0 33.26
33.27	GME CONSORTIUM FEES	A	200,000	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00		0 33.27
33.28	AHA LOBBYING OFFSET	A	-10,007	ADMINISTRATIVE & GENERAL	5.00		0 33.28
33.29	IHA LOBBYING OFFSET	A	-5,215	ADMINISTRATIVE & GENERAL	5.00		0 33.29
33.30	INDIANA CHAMBER LOBBYING OFFSET	A	-1,399	ADMINISTRATIVE & GENERAL	5.00		0 33.30
33.31	IHRA LOBBYING OFFSET	A	-5,000	ADMINISTRATIVE & GENERAL	5.00		0 33.31
33.32	PROVIDER ASSESSMENT FEE	A	-12,162,805	ADMINISTRATIVE & GENERAL	5.00		0 33.32
33.33	RENTAL	A	-43,473	ADMINISTRATIVE & GENERAL	5.00		0 33.33
33.34	RENTAL	A	-19,620	OPERATING ROOM	50.00		0 33.34
33.35	RENTAL	A	-2,700	ELECTROCARDIOLOGY	69.00		0 33.35
33.36	RENTAL	A	-208,995	INPATIENT DIALYSIS	76.01		0 33.36
33.37	PHYSICIAN LOAN EXPENSE	A	-55,703	ADMINISTRATIVE & GENERAL	5.00		0 33.37
33.38	PHYSICIAN LOAN EXPENSE	A	-20,000	OPERATING ROOM	50.00		0 33.38
33.39	PHYSICIAN LOAN EXPENSE	A	-20,000	RADIOLOGY-THERAPEUTIC	55.00		0 33.39
33.40	OTHER MISC FEES	B	-592,822	CAFETERIA	11.00		0 33.40
33.41	DONATIONS EXPENSE	B	-244,850	ADMINISTRATIVE & GENERAL	5.00		0 33.41
33.42	TELEPHONE OFFSET	A	-58,499	COMMUNICATIONS	4.01		0 33.42
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-26,707,240				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0042

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

Worksheet A-8-2

Date/Time Prepared:  
5/26/2022 9:38 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	321,297	12,690	308,607	211,500	2,129	1.00
2.00	13.00	NURSING ADMINISTRATION	137,695	137,695	0	211,500	0	2.00
3.00	15.00	PHARMACY	23,785	0	23,785	211,500	156	3.00
4.00	40.00	SUBPROVIDER - IPF	282,799	227,799	55,000	211,500	240	4.00
5.00	50.00	OPERATING ROOM	2,400,990	2,400,990	0	246,400	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	13,612	13,612	0	271,900	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	1,128,820	1,093,506	35,314	271,900	167	7.00
8.00	60.00	LABORATORY	141,201	1,200	140,001	260,300	2,978	8.00
9.00	65.00	RESPIRATORY THERAPY	1,083,277	1,061,827	21,450	211,500	278	9.00
10.00	69.00	ELECTROCARDIOLOGY	3,199,737	3,199,737	0	211,500	0	10.00
11.00	70.01	NEURODIAGNOSTICS	16,500	0	16,500	211,500	110	11.00
12.00	75.00	ASC (NON-DISTINCT PART)	103,850	68,750	35,100	211,500	288	12.00
13.00	76.01	INPATIENT DIALYSIS	40,560	0	40,560	211,500	641	13.00
14.00	91.00	EMERGENCY	1,261,922	1,251,252	10,670	211,500	244	14.00
200.00			10,156,045	9,469,058	686,987		7,231	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	ADMINISTRATIVE & GENERAL	216,483	10,824	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	15.00	PHARMACY	15,863	793	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	24,404	1,220	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	21,830	1,092	0	0	0	7.00
8.00	60.00	LABORATORY	372,680	18,634	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	28,268	1,413	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	70.01	NEURODIAGNOSTICS	11,185	559	0	0	0	11.00
12.00	75.00	ASC (NON-DISTINCT PART)	29,285	1,464	0	0	0	12.00
13.00	76.01	INPATIENT DIALYSIS	65,179	3,259	0	0	0	13.00
14.00	91.00	EMERGENCY	24,811	1,241	0	0	0	14.00
200.00			809,988	40,499	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	ADMINISTRATIVE & GENERAL	0	216,483	92,124	104,814		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	137,695		2.00
3.00	15.00	PHARMACY	0	15,863	7,922	7,922		3.00
4.00	40.00	SUBPROVIDER - IPF	0	24,404	30,596	258,395		4.00
5.00	50.00	OPERATING ROOM	0	0	0	2,400,990		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	13,612		6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	0	21,830	13,484	1,106,990		7.00
8.00	60.00	LABORATORY	0	372,680	0	1,200		8.00
9.00	65.00	RESPIRATORY THERAPY	0	28,268	0	1,061,827		9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	3,199,737		10.00
11.00	70.01	NEURODIAGNOSTICS	0	11,185	5,315	5,315		11.00
12.00	75.00	ASC (NON-DISTINCT PART)	0	29,285	5,815	74,565		12.00
13.00	76.01	INPATIENT DIALYSIS	0	65,179	0	0		13.00
14.00	91.00	EMERGENCY	0	24,811	0	1,251,252		14.00
200.00			0	809,988	155,256	9,624,314		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4.01	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	20,960,881	20,960,881			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	95,144		95,144		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	30,729,053	115,220	523	30,844,796	4.00
4.01 00401	COMMUNICATIONS	225,854	0	0	81,222	4.01
4.02 00402	PURCHASING & RECEIVING	745,935	274,305	1,245	192,833	4.02
4.03 00403	REGISTRATION	1,792,015	267,883	1,216	497,372	4.03
4.04 00404	PATIENT ACCOUNTS	4,228,686	0	0	753,089	4.04
5.00 00500	ADMINISTRATIVE & GENERAL	14,916,633	1,136,701	5,160	2,064,990	5.00
7.00 00700	OPERATION OF PLANT	6,304,566	5,685,875	25,811	663,206	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	289,441	124,794	566	63,322	8.00
9.00 00900	HOUSEKEEPING	2,257,719	173,612	788	585,434	9.00
10.00 01000	DIETARY	1,002,514	102,233	464	171,092	10.00
11.00 01100	CAFETERIA	997,318	194,443	883	325,403	11.00
13.00 01300	NURSING ADMINISTRATION	3,484,162	231,364	1,050	655,745	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	560,929	94,010	427	102,667	14.00
15.00 01500	PHARMACY	3,173,904	141,691	643	834,192	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	4,032,674	108,537	493	1,036,470	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
17.01 01701	MENTAL HEALTH OH	717,285	61,733	280	136,141	17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,186,999	240,393	1,091	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,967,142	0	0	404,398	22.00
23.00 02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	23.00
23.01 02301	PARAMED ED PRGM-LAB	226,267	0	0	68,829	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	7,591,890	1,450,795	6,585	1,452,126	30.00
31.00 03100	INTENSIVE CARE UNIT	4,975,492	496,569	2,254	937,621	31.00
40.00 04000	SUBPROVIDER - IPF	1,978,440	308,880	1,402	588,086	40.00
41.00 04100	SUBPROVIDER - IRF	2,448,641	407,441	1,849	582,850	41.00
43.00 04300	NURSERY	369,786	0	0	97,065	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	3,230,022	569,369	2,584	930,456	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
51.01 05101	ENDOSCOPY	1,297,961	289,993	1,316	209,340	51.01
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,138,169	0	0	291,223	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	6,179,093	513,442	2,331	1,033,533	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	2,816,003	426,210	1,935	776,607	55.00
60.00 06000	LABORATORY	7,178,952	172,948	785	661,133	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00 06500	RESPIRATORY THERAPY	2,477,931	134,581	611	713,767	65.00
66.00 06600	PHYSICAL THERAPY	4,015,237	362,035	1,643	1,103,579	66.00
69.00 06900	ELECTROCARDIOLOGY	2,519,461	430,854	1,956	1,441,322	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01 07001	NEURODIAGNOSTICS	1,212,831	182,665	829	121,063	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,812,175	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	3,550,584	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	16,275,193	0	0	0	73.00
75.00 07500	ASC (NON-DISTINCT PART)	1,607,678	0	0	293,725	75.00
76.00 03950	MH ANCILLARY OUTPATIENT	0	0	0	0	76.00
76.01 03951	INPATIENT DIALYSIS	267,335	203,377	923	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	78,722	53,415	242	22,201	90.00
90.01 04950	WOUND CLINIC	1,062,260	70,525	320	113,384	90.01
91.00 09100	EMERGENCY	4,924,494	560,909	2,546	1,210,480	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	158,175	9,337	42	26,925	96.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	620,763	115,196	523	128,569	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	182,682,409	15,711,335	71,316	21,371,460	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	31,043,080	3,033,280	13,768	6,272,417	192.00
192.01 19201	FP PETERSBURG	434,654	87,801	399	66,585	192.01
192.02 19202	PEDIATRICS	1,381,919	0	0	312,619	192.02
192.03 19203	WASHINGTON PRIMARY CARE	1,567,189	161,147	731	392,065	192.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

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

Worksheet B  
Part I  
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4.01	
192.04 19204 FQHC	9,660	0	0	2,768	0	192.04
194.00 07950 COMMUNITY HEALTH SERVICES	134,989	9,835	45	29,016	409	194.00
194.01 07960 CCBHC GRANTS	1,754,012	0	0	389,059	0	194.01
194.02 07952 MARKETING AND PUBLIC RELATIONS	824,050	40,050	182	67,565	545	194.02
194.03 07953 MH RESIDENTIAL	537,581	480,123	2,179	139,069	0	194.03
194.04 07954 UNUSED SPACE	0	482,729	2,191	0	0	194.04
194.05 07955 MOB	41,971	0	0	0	0	194.05
194.06 07956 FOUNDATION	0	11,043	50	0	272	194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	111,665	507	0	0	194.07
194.08 07958 INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	6,899,221	831,873	3,776	1,802,173	0	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	227,310,735	20,960,881	95,144	30,844,796	307,076	202.00

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/26/2022 9:38 am	
Cost Center Description			PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL
			4.02	4.03	4.04	4A.04	5.00
<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
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	PURCHASING & RECEIVING	1,217,042				4.02
4.03	00403	REGISTRATION	812	2,564,064			4.03
4.04	00404	PATIENT ACCOUNTS	674	0	4,988,441		4.04
5.00	00500	ADMINISTRATIVE & GENERAL	3,034	0	0	18,150,076	18,150,076
7.00	00700	OPERATION OF PLANT	8,463	0	0	12,704,262	1,102,425
8.00	00800	LAUNDRY & LINEN SERVICE	4,185	0	0	482,308	41,853
9.00	00900	HOUSEKEEPING	13,887	0	0	3,036,478	263,493
10.00	01000	DIETARY	26,196	0	0	1,303,725	113,132
11.00	01100	CAFETERIA	49,823	0	0	1,570,321	136,266
13.00	01300	NURSING ADMINISTRATION	42,015	0	0	4,416,923	383,283
14.00	01400	CENTRAL SERVICES & SUPPLY	4,435	0	0	763,421	66,247
15.00	01500	PHARMACY	2,530	0	0	4,157,454	360,767
16.00	01600	MEDICAL RECORDS & LIBRARY	349	0	0	5,185,604	449,986
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
17.01	01701	MENTAL HEALTH OH	529	0	0	950,148	82,450
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	2,428,483	210,734
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,513	0	0	2,379,862	206,515
23.00	02300	PARAMED PRGM-RADIOLOGY	0	0	0	0	0
23.01	02301	PARAMED PRGM-LAB	281	0	0	295,377	25,632
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	23,461	113,929	221,641	10,882,079	944,303
31.00	03100	INTENSIVE CARE UNIT	21,504	65,778	127,966	6,640,529	576,239
40.00	04000	SUBPROVIDER - IPF	1,679	36,237	70,497	2,985,221	259,046
41.00	04100	SUBPROVIDER - IRF	5,987	31,378	61,043	3,548,857	307,956
43.00	04300	NURSERY	1,546	5,552	10,801	484,750	42,065
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	46,698	189,295	368,261	5,356,975	464,857
51.00	05100	RECOVERY ROOM	0	0	0	0	0
51.01	05101	ENDOSCOPY	27,326	45,535	88,586	1,963,598	170,393
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,595	31,570	61,417	1,536,553	133,336
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,305	395,101	768,870	8,924,254	774,411
55.00	05500	RADIOLOGY-THERAPEUTIC	5,795	97,176	189,049	4,317,677	374,671
60.00	06000	LABORATORY	83,600	291,399	566,897	8,960,480	777,555
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,099	57,807	112,460	3,503,703	304,037
66.00	06600	PHYSICAL THERAPY	3,056	102,715	199,825	5,791,767	502,586
69.00	06900	ELECTROCARDIOLOGY	9,490	193,097	375,657	4,982,595	432,370
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
70.01	07001	NEURODIAGNOSTICS	6,324	26,429	51,416	1,604,281	139,213
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	459,351	7	14	4,271,547	370,668
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	230,461	0	0	3,781,045	328,104
73.00	07300	DRUGS CHARGED TO PATIENTS	0	272,491	530,112	17,077,796	1,481,943
75.00	07500	ASC (NON-DISTINCT PART)	22,765	100,695	195,896	2,220,759	192,709
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0
76.01	03951	INPATIENT DIALYSIS	127	3,966	7,715	483,852	41,987
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	9	347	675	156,837	13,610
90.01	04950	WOUND CLINIC	7,637	24,332	47,336	1,327,156	115,165
91.00	09100	EMERGENCY	24,171	201,019	391,068	7,328,985	635,980
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	670	1,584	3,082	199,815	17,339
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	792	7,860	15,291	892,126	77,415
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,171,174	2,295,299	4,465,575	167,047,679	12,920,741
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	33,921	206,412	401,560	41,053,733	3,562,428
192.01	19201	FP PETERSBURG	86	2,185	4,252	595,962	51,715
192.02	19202	PEDIATRICS	930	11,155	21,701	1,728,324	149,977
192.03	19203	WASHINGTON PRIMARY CARE	1,421	12,272	23,874	2,158,699	187,323
192.04	19204	FQHC	0	0	0	12,428	1,078
194.00	07950	COMMUNITY HEALTH SERVICES	323	278	542	175,437	15,224
194.01	07960	CCBHC GRANTS	3,566	2,951	5,741	2,155,329	187,031
194.02	07952	MARKETING AND PUBLIC RELATIONS	14	0	0	932,406	80,910
194.03	07953	MH RESIDENTIAL	1,878	651	1,267	1,162,748	100,899

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

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

Worksheet B  
Part I  
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Cost Center Description			PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL	
			4.02	4.03	4.04	4A.04	5.00	
194.04	07954	UNUSED SPACE	0	0	0	484,920	42,079	194.04
194.05	07955	MOB	1	0	0	41,972	3,642	194.05
194.06	07956	FOUNDATION	0	0	0	11,365	986	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	112,172	9,734	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	3,728	32,861	63,929	9,637,561	836,309	194.09
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,217,042	2,564,064	4,988,441	227,310,735	18,150,076	202.00



COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0042		Period: From 01/01/2021 To 12/31/2021		Worksheet B Part I Date/Time Prepared: 5/26/2022 9:38 am	
Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
<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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	13,806,687					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	127,810	651,971				8.00
9.00	00900	HOUSEKEEPING	177,808	41,502	3,519,281			9.00
10.00	01000	DIETARY	104,704	2,199	96,284	1,620,044		10.00
11.00	01100	CAFETERIA	199,142	4,183	22,992	0	1,932,904	11.00
13.00	01300	NURSING ADMINISTRATION	236,955	0	0	0	52,483	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	96,282	9,362	40,802	0	16,462	14.00
15.00	01500	PHARMACY	145,115	0	32,329	0	62,948	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	111,160	0	27,633	0	113,496	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	63,225	0	100,926	0	11,949	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	246,203	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	52,136	0	24,190	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	0	6,045	23.01
<b>INPATIENT SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,485,856	219,020	866,070	751,117	154,109	30.00
31.00	03100	INTENSIVE CARE UNIT	508,569	54,488	242,275	272,198	84,368	31.00
40.00	04000	SUBPROVIDER - IPF	316,345	14,389	0	240,889	58,753	40.00
41.00	04100	SUBPROVIDER - IRF	417,287	39,063	154,465	355,840	60,402	41.00
43.00	04300	NURSERY	0	1,483	8,959	0	8,291	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	583,129	23,661	200,772	0	62,448	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	297,001	18,210	54,403	0	23,142	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,731	11,820	0	26,231	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	525,850	41,148	113,231	0	95,436	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	436,510	6,957	59,530	0	56,897	55.00
60.00	06000	LABORATORY	177,128	0	51,974	0	88,212	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	137,834	128	40,046	0	57,582	65.00
66.00	06600	PHYSICAL THERAPY	370,784	7,081	94,719	0	102,380	66.00
69.00	06900	ELECTROCARDIOLOGY	441,267	14,828	117,818	0	79,423	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	187,079	9,256	35,621	0	13,632	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	24,929	157,811	0	33,390	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	208,292	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	54,706	0	59,746	0	2,495	90.00
90.01	04950	WOUND CLINIC	72,230	7,498	18,890	0	9,821	90.01
91.00	09100	EMERGENCY	574,465	81,894	239,577	0	110,037	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	9,563	0	0	0	3,214	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	117,980	0	49,060	0	14,131	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,430,279	629,010	2,949,889	1,620,044	1,431,967	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,106,583	22,961	548,722	0	361,151	192.00
192.01	19201	FP PETERSBURG	89,923	0	0	0	6,689	192.01
192.02	19202	PEDIATRICS	0	0	0	0	23,784	192.02
192.03	19203	WASHINGTON PRIMARY CARE	165,041	0	0	0	29,601	192.03
192.04	19204	FQHC	0	0	0	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	10,072	0	17,702	0	3,350	194.00
194.01	07960	CCBHC GRANTS	0	0	0	0	44,287	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	41,018	0	2,968	0	7,054	194.02
194.03	07953	MH RESIDENTIAL	491,726	0	0	0	25,021	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:  
From 01/01/2021  
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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.04	07954	UNUSED SPACE	494,395	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	11,310	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	114,364	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	851,976	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,806,687	651,971	3,519,281	1,620,044	1,932,904	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:  
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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
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	5,089,644					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	992,576				14.00
15.00	01500	PHARMACY	0	2,361	4,760,974			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	325	0	5,888,204		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	494	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	166,854	1,412	2,406	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	262	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,013,911	21,896	69	723,611	0	30.00
31.00	03100	INTENSIVE CARE UNIT	581,929	20,069	15	695,234	0	31.00
40.00	04000	SUBPROVIDER - I PF	402,741	1,567	6	837,118	0	40.00
41.00	04100	SUBPROVIDER - I RF	416,623	5,588	3	354,711	0	41.00
43.00	04300	NURSERY	57,186	1,443	40	113,508	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	316,302	43,583	3,917	425,653	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	159,623	25,503	10,466	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	229,989	5,222	136	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,348	21,751	72,884	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	272,612	5,409	981	0	0	55.00
60.00	06000	LABORATORY	0	78,024	18	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,025	323	0	0	65.00
66.00	06600	PHYSICAL THERAPY	228,846	2,852	748	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,857	17,587	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	22,262	5,902	6	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	428,713	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	215,089	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,214,081	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	230,311	21,246	6,678	1,631,671	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	118	808	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	9	4	0	0	90.00
90.01	04950	WOUND CLINIC	17,866	7,127	3,980	141,884	0	90.01
91.00	09100	EMERGENCY	758,982	22,558	3,008	964,814	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	625	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	97,472	739	7	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,040,857	949,769	4,338,171	5,888,204	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	48,787	31,658	340,482	0	0	192.00
192.01	19201	FP PETERSBURG	0	80	3,103	0	0	192.01
192.02	19202	PEDIATRICS	0	868	60,551	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	1,326	18,032	0	0	192.03
192.04	19204	FOHC	0	0	0	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	302	129	0	0	194.00
194.01	07960	CCBHC GRANTS	0	3,328	377	0	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	13	0	0	0	194.02

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:  
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Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	13.00	14.00	15.00	16.00	17.00	
194.03 07953 MH RESIDENTIAL	0	1,753	128	0	0	194.03
194.04 07954 UNUSED SPACE	0	0	0	0	0	194.04
194.05 07955 MOB	0	0	0	0	0	194.05
194.06 07956 FOUNDATION	0	0	0	0	0	194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08 07958 INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	0	3,479	1	0	0	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	5,089,644	992,576	4,760,974	5,888,204	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:  
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Cost Center Description	INTERNS & RESIDENTS					PARAMED PRGM-RADIOLOGY	PARAMED PRGM-LAB	
	MENTAL HEALTH OH	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS					
	17.01	21.00	22.00	23.00	23.01			
<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
4.01 00401	COMMUNICATIONS							4.01
4.02 00402	PURCHASING & RECEIVING							4.02
4.03 00403	REGISTRATION							4.03
4.04 00404	PATIENT ACCOUNTS							4.04
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
17.01 01701	MENTAL HEALTH OH	1,209,192						17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	2,885,420					21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	2,833,375				22.00
23.00 02300	PARAMED PRGM-RADIOLOGY	0	0	0	0			23.00
23.01 02301	PARAMED PRGM-LAB	0	0	0	0	327,316		23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00 03000	ADULTS & PEDIATRICS	0	903,959	887,653	0	0		30.00
31.00 03100	INTENSIVE CARE UNIT	0	176,840	173,650	0	0		31.00
40.00 04000	SUBPROVIDER - I PF	634,134	504,833	495,727	0	0		40.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0		41.00
43.00 04300	NURSERY	0	0	0	0	0		43.00
<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
51.01 05101	ENDOSCOPY	0	0	0	0	0		51.01
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0		52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0		53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0		54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	18,441	18,109	0	0		55.00
60.00 06000	LABORATORY	0	0	0	0	327,316		60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0		63.00
65.00 06500	RESPIRATORY THERAPY	0	51,372	50,446	0	0		65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	0		66.00
69.00 06900	ELECTROCARDIOLOGY	0	110,648	108,653	0	0		69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0		70.00
70.01 07001	NEURODIAGNOSTICS	0	0	0	0	0		70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0		71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0		72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0		73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	491,332	482,469	0	0		75.00
76.00 03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0		76.00
76.01 03951	INPATIENT DIALYSIS	0	59,276	58,207	0	0		76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00 09000	CLINIC	0	0	0	0	0		90.00
90.01 04950	WOUND CLINIC	0	0	0	0	0		90.01
91.00 09100	EMERGENCY	0	150,495	147,780	0	0		91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0		96.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00 11300	INTEREST EXPENSE							113.00
116.00 11600	HOSPICE	0			0			116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	634,134	2,467,196	2,422,694	0	327,316		118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0		190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	212,076	208,251	0	0		192.00
192.01 19201	FP PETERSBURG	0	0	0	0	0		192.01
192.02 19202	PEDIATRICS	0	0	0	0	0		192.02
192.03 19203	WASHINGTON PRIMARY CARE	0	0	0	0	0		192.03
192.04 19204	FOHC	0	0	0	0	0		192.04
194.00 07950	COMMUNITY HEALTH SERVICES	0	0	0	0	0		194.00
194.01 07960	CCBHC GRANTS	0	0	0	0	0		194.01

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:  
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Cost Center Description	INTERNS & RESIDENTS					
	MENTAL HEALTH	SERVICES-SALAR	SERVICES-OTHER	PARAMED ED	PARAMED ED	
	OH	Y & FRINGES	PRGM COSTS	PRGM-RADIOLOGY	PRGM-LAB	
	17.01	21.00	22.00	23.00	23.01	
194.02 07952 MARKETING AND PUBLIC RELATIONS	0	0	0	0	0	0 194.02
194.03 07953 MH RESIDENTIAL	0	0	0	0	0	0 194.03
194.04 07954 UNUSED SPACE	0	0	0	0	0	0 194.04
194.05 07955 MOB	0	0	0	0	0	0 194.05
194.06 07956 FOUNDATION	0	0	0	0	0	0 194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	0	0	0	0 194.07
194.08 07958 INDUSTRIAL HEALTH	0	0	0	0	0	0 194.08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	575,058	206,148	202,430	0	0	0 194.09
200.00 Cross Foot Adjustments	0	0	0	0	0	0 200.00
201.00 Negative Cost Centers	0	0	0	0	0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	1,209,192	2,885,420	2,833,375	0	327,316	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	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
4.01	00401	COMMUNICATIONS				4.01
4.02	00402	PURCHASING & RECEIVING				4.02
4.03	00403	REGISTRATION				4.03
4.04	00404	PATIENT ACCOUNTS				4.04
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
17.01	01701	MENTAL HEALTH OH				17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY				23.00
23.01	02301	PARAMED ED PRGM-LAB				23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	18,853,653	-1,791,612	17,062,041	30.00
31.00	03100	INTENSIVE CARE UNIT	10,026,403	-350,490	9,675,913	31.00
40.00	04000	SUBPROVIDER - I PF	6,750,769	-1,000,560	5,750,209	40.00
41.00	04100	SUBPROVIDER - I RF	5,660,795	0	5,660,795	41.00
43.00	04300	NURSERY	717,725	0	717,725	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	7,481,297	0	7,481,297	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
51.01	05101	ENDOSCOPY	2,722,339	0	2,722,339	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,951,018	0	1,951,018	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,636,313	0	10,636,313	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,567,794	-36,550	5,531,244	55.00
60.00	06000	LABORATORY	10,460,707	0	10,460,707	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	4,146,496	-101,818	4,044,678	65.00
66.00	06600	PHYSICAL THERAPY	7,101,763	0	7,101,763	66.00
69.00	06900	ELECTROCARDIOLOGY	6,314,046	-219,301	6,094,745	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	2,017,252	0	2,017,252	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,070,928	0	5,070,928	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,324,238	0	4,324,238	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,773,820	0	22,773,820	73.00
75.00	07500	ASC (NON-DISTINCT PART)	5,493,305	-973,801	4,519,504	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	852,540	-117,483	735,057	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	287,407	0	287,407	90.00
90.01	04950	WOUND CLINIC	1,721,617	0	1,721,617	90.01
91.00	09100	EMERGENCY	11,018,575	-298,275	10,720,300	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	230,556	0	230,556	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE	0	0	0	113.00
116.00	11600	HOSPICE	1,248,930	0	1,248,930	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	153,430,286	-4,889,890	148,540,396	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	49,496,832	-420,327	49,076,505	192.00
192.01	19201	FP PETERSBURG	747,472	0	747,472	192.01
192.02	19202	PEDIATRICS	1,963,504	0	1,963,504	192.02
192.03	19203	WASHINGTON PRIMARY CARE	2,560,022	0	2,560,022	192.03
192.04	19204	FOHC	13,506	0	13,506	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	222,216	0	222,216	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

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

Worksheet B  
Part I  
Date/Time Prepared:  
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
194.01	07960	CCBHC GRANTS	2,390,352	0	2,390,352	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	1,064,369	0	1,064,369	194.02
194.03	07953	MH RESIDENTIAL	1,782,275	0	1,782,275	194.03
194.04	07954	UNUSED SPACE	1,021,394	0	1,021,394	194.04
194.05	07955	MOB	45,614	0	45,614	194.05
194.06	07956	FOUNDATION	23,661	0	23,661	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	236,270	0	236,270	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	12,312,962	-408,578	11,904,384	194.09
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	227,310,735	-5,718,795	221,591,940	202.00



ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/26/2022 9:38 am

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT		
			BLDG & FIXT	MVBLE EQUIP				
			0	1.00				2.00
<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	115,220	523	115,743	115,743	4.00
4.01	00401	COMMUNICATIONS	0	0	0	0	305	4.01
4.02	00402	PURCHASING & RECEIVING	0	274,305	1,245	275,550	723	4.02
4.03	00403	REGISTRATION	0	267,883	1,216	269,099	1,866	4.03
4.04	00404	PATIENT ACCOUNTS	0	0	0	0	2,825	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,136,701	5,160	1,141,861	7,747	5.00
7.00	00700	OPERATION OF PLANT	0	5,685,875	25,811	5,711,686	2,488	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	124,794	566	125,360	238	8.00
9.00	00900	HOUSEKEEPING	0	173,612	788	174,400	2,196	9.00
10.00	01000	DIETARY	0	102,233	464	102,697	642	10.00
11.00	01100	CAFETERIA	0	194,443	883	195,326	1,221	11.00
13.00	01300	NURSING ADMINISTRATION	0	231,364	1,050	232,414	2,460	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	94,010	427	94,437	385	14.00
15.00	01500	PHARMACY	0	141,691	643	142,334	3,130	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	108,537	493	109,030	3,889	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	61,733	280	62,013	511	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	240,393	1,091	241,484	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	1,517	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	0	258	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	1,450,795	6,585	1,457,380	5,448	30.00
31.00	03100	INTENSIVE CARE UNIT	0	496,569	2,254	498,823	3,518	31.00
40.00	04000	SUBPROVIDER - I PF	0	308,880	1,402	310,282	2,206	40.00
41.00	04100	SUBPROVIDER - I RF	0	407,441	1,849	409,290	2,187	41.00
43.00	04300	NURSERY	0	0	0	0	364	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	569,369	2,584	571,953	3,491	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	289,993	1,316	291,309	785	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	1,093	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	513,442	2,331	515,773	3,878	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	426,210	1,935	428,145	2,914	55.00
60.00	06000	LABORATORY	0	172,948	785	173,733	2,480	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	134,581	611	135,192	2,678	65.00
66.00	06600	PHYSICAL THERAPY	0	362,035	1,643	363,678	4,140	66.00
69.00	06900	ELECTROCARDIOLOGY	0	430,854	1,956	432,810	5,407	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	182,665	829	183,494	454	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	1,102	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	203,377	923	204,300	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	53,415	242	53,657	83	90.00
90.01	04950	WOUND CLINIC	0	70,525	320	70,845	425	90.01
91.00	09100	EMERGENCY	0	560,909	2,546	563,455	4,541	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	9,337	42	9,379	101	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	115,196	523	115,719	482	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	15,711,335	71,316	15,782,651	80,178	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,033,280	13,768	3,047,048	23,556	192.00
192.01	19201	FP PETERSBURG	0	87,801	399	88,200	250	192.01
192.02	19202	PEDIATRICS	0	0	0	0	1,173	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	161,147	731	161,878	1,471	192.03
192.04	19204	FQHC	0	0	0	0	10	192.04

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

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

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
194.00 07950 COMMUNITY HEALTH SERVICES	0	9,835	45	9,880	109	194.00
194.01 07960 CCBHC GRANTS	0	0	0	0	1,460	194.01
194.02 07952 MARKETING AND PUBLIC RELATIONS	0	40,050	182	40,232	253	194.02
194.03 07953 MH RESIDENTIAL	0	480,123	2,179	482,302	522	194.03
194.04 07954 UNUSED SPACE	0	482,729	2,191	484,920	0	194.04
194.05 07955 MOB	0	0	0	0	0	194.05
194.06 07956 FOUNDATION	0	11,043	50	11,093	0	194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	111,665	507	112,172	0	194.07
194.08 07958 INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	0	831,873	3,776	835,649	6,761	194.09
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	20,960,881	95,144	21,056,025	115,743	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0042		Period: From 01/01/2021 To 12/31/2021		Worksheet B Part II Date/Time Prepared: 5/26/2022 9:38 am	
Cost Center Description			COMMUNICATIONS	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	ADMINISTRATIVE & GENERAL	
			4.01	4.02	4.03	4.04	5.00	
<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
4.01	00401	COMMUNICATIONS	305					4.01
4.02	00402	PURCHASING & RECEIVING	3	276,276				4.02
4.03	00403	REGISTRATION	5	184	271,154			4.03
4.04	00404	PATIENT ACCOUNTS	6	153	0	2,984		4.04
5.00	00500	ADMINISTRATIVE & GENERAL	23	689	0	0	1,150,320	5.00
7.00	00700	OPERATION OF PLANT	16	1,921	0	0	69,873	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	950	0	0	2,653	8.00
9.00	00900	HOUSEKEEPING	5	3,152	0	0	16,701	9.00
10.00	01000	DIETARY	1	5,947	0	0	7,170	10.00
11.00	01100	CAFETERIA	2	11,310	0	0	8,637	11.00
13.00	01300	NURSING ADMINISTRATION	3	9,537	0	0	24,293	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1	1,007	0	0	4,199	14.00
15.00	01500	PHARMACY	4	574	0	0	22,866	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7	79	0	0	28,521	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	34	120	0	0	5,226	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	13,357	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	7	343	0	0	13,089	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	64	0	0	1,625	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	22	5,326	12,053	147	59,851	30.00
31.00	03100	INTENSIVE CARE UNIT	13	4,881	6,959	85	36,523	31.00
40.00	04000	SUBPROVIDER - IPF	0	381	3,834	47	16,419	40.00
41.00	04100	SUBPROVIDER - IRF	10	1,359	3,320	40	19,519	41.00
43.00	04300	NURSERY	0	351	587	7	2,666	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	20	10,601	20,026	244	29,463	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	4	6,203	4,817	59	10,800	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	9	1,270	3,340	41	8,451	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9	5,290	41,695	191	49,083	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5	1,316	10,280	125	23,747	55.00
60.00	06000	LABORATORY	5	18,977	30,828	375	49,283	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	5	249	6,116	74	19,270	65.00
66.00	06600	PHYSICAL THERAPY	4	694	10,866	132	31,855	66.00
69.00	06900	ELECTROCARDIOLOGY	11	2,154	20,428	249	27,404	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	3	1,435	2,796	34	8,824	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	104,282	1	0	23,494	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	52,315	0	0	20,796	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	28,827	351	93,928	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	5,168	10,653	130	12,214	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	29	420	5	2,661	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	1	2	37	0	863	90.00
90.01	04950	WOUND CLINIC	1	1,734	2,574	31	7,299	90.01
91.00	09100	EMERGENCY	14	5,487	21,266	259	40,309	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	152	168	2	1,099	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3	180	831	10	4,907	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	256	265,866	242,722	2,638	818,938	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	48	7,700	21,837	266	225,730	192.00
192.01	19201	FP PETERSBURG	0	20	231	3	3,278	192.01
192.02	19202	PEDIATRICS	0	211	1,180	14	9,506	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	322	1,298	16	11,873	192.03
192.04	19204	FOHC	0	0	0	0	68	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	73	29	0	965	194.00
194.01	07960	CCBHC GRANTS	0	809	312	4	11,854	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	1	3	0	0	5,128	194.02
194.03	07953	MH RESIDENTIAL	0	426	69	1	6,395	194.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

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

Worksheet B  
Part II  
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Cost Center Description			COMMUNICATIONS	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	ADMINISTRATIVE & GENERAL	
			4.01	4.02	4.03	4.04	5.00	
194.04	07954	UNUSED SPACE	0	0	0	0	2,667	194.04
194.05	07955	MOB	0	0	0	0	231	194.05
194.06	07956	FOUNDATION	0	0	0	0	63	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	617	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	846	3,476	42	53,007	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	305	276,276	271,154	2,984	1,150,320	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/26/2022 9:38 am			
Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
<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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	5,785,984					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	53,561	182,762				8.00
9.00	00900	HOUSEKEEPING	74,514	11,634	282,602			9.00
10.00	01000	DIETARY	43,878	616	7,732	168,683		10.00
11.00	01100	CAFETERIA	83,454	1,173	1,846	0	302,969	11.00
13.00	01300	NURSING ADMINISTRATION	99,301	0	0	0	8,226	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	40,349	2,624	3,276	0	2,580	14.00
15.00	01500	PHARMACY	60,813	0	2,596	0	9,867	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46,584	0	2,219	0	17,790	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	26,496	0	8,104	0	1,873	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	103,176	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	4,187	0	3,792	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	0	947	23.01
<b>INPATIENT SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	622,679	61,395	69,546	78,208	24,155	30.00
31.00	03100	INTENSIVE CARE UNIT	213,127	15,274	19,455	28,342	13,224	31.00
40.00	04000	SUBPROVIDER - IPF	132,571	4,034	0	25,082	9,209	40.00
41.00	04100	SUBPROVIDER - IRF	174,873	10,950	12,404	37,051	9,468	41.00
43.00	04300	NURSERY	0	416	719	0	1,300	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	244,373	6,633	16,122	0	9,788	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	124,465	5,105	4,369	0	3,627	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,167	949	0	4,112	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	220,369	11,535	9,093	0	14,959	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	182,929	1,950	4,780	0	8,918	55.00
60.00	06000	LABORATORY	74,229	0	4,174	0	13,827	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	57,762	36	3,216	0	9,026	65.00
66.00	06600	PHYSICAL THERAPY	155,385	1,985	7,606	0	16,047	66.00
69.00	06900	ELECTROCARDIOLOGY	184,922	4,157	9,461	0	12,449	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	78,399	2,595	2,860	0	2,137	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	6,988	12,672	0	5,234	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	87,289	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	22,926	0	4,798	0	391	90.00
90.01	04950	WOUND CLINIC	30,269	2,102	1,517	0	1,539	90.01
91.00	09100	EMERGENCY	240,742	22,957	19,238	0	17,247	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	4,007	0	0	0	504	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	49,442	0	3,940	0	2,215	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,532,884	176,326	236,879	168,683	224,451	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,301,881	6,436	44,063	0	56,607	192.00
192.01	19201	FP PETERSBURG	37,684	0	0	0	1,048	192.01
192.02	19202	PEDIATRICS	0	0	0	0	3,728	192.02
192.03	19203	WASHINGTON PRIMARY CARE	69,164	0	0	0	4,640	192.03
192.04	19204	FOHC	0	0	0	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	4,221	0	1,422	0	525	194.00
194.01	07960	CCBHC GRANTS	0	0	0	0	6,942	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	17,189	0	238	0	1,106	194.02
194.03	07953	MH RESIDENTIAL	206,068	0	0	0	3,922	194.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

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

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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.04	07954	UNUSED SPACE	207,187	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	4,740	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	47,927	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	357,039	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,785,984	182,762	282,602	168,683	302,969	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0042		Period: From 01/01/2021 To 12/31/2021		Worksheet B Part II Date/Time Prepared: 5/26/2022 9:38 am	
Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
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	376,234					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	148,858				14.00
15.00	01500	PHARMACY	0	354	242,538			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	49	0	208,168		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	74	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	12,334	212	123	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	39	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	74,950	3,284	4	25,582	0	30.00
31.00	03100	INTENSIVE CARE UNIT	43,017	3,010	1	24,579	0	31.00
40.00	04000	SUBPROVIDER - I/PF	29,771	235	0	29,595	0	40.00
41.00	04100	SUBPROVIDER - I/RF	30,797	838	0	12,540	0	41.00
43.00	04300	NURSERY	4,227	216	2	4,013	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	23,382	6,536	200	15,048	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	11,800	3,825	533	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,001	783	7	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,978	3,262	3,713	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	20,152	811	50	0	0	55.00
60.00	06000	LABORATORY	0	11,702	1	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	154	16	0	0	65.00
66.00	06600	PHYSICAL THERAPY	16,917	428	38	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,328	896	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	1,646	885	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	64,293	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,258	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	214,676	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	17,025	3,186	340	57,686	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	18	41	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	1	0	0	0	90.00
90.01	04950	WOUND CLINIC	1,321	1,069	203	5,016	0	90.01
91.00	09100	EMERGENCY	56,105	3,383	153	34,109	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	94	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	7,205	111	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	372,628	142,438	220,997	208,168	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,606	4,748	17,346	0	0	192.00
192.01	19201	FP PETERSBURG	0	12	158	0	0	192.01
192.02	19202	PEDIATRICS	0	130	3,085	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	199	919	0	0	192.03
192.04	19204	FOHC	0	0	0	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	45	7	0	0	194.00
194.01	07960	CCBHC GRANTS	0	499	19	0	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	2	0	0	0	194.02

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0042			Period: From 01/01/2021 To 12/31/2021		Worksheet B Part II Date/Time Prepared: 5/26/2022 9:38 am	
Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
		13.00	14.00	15.00	16.00	17.00		
194.03	07953 MH RESIDENTIAL	0	263	7	0	0	194.03	
194.04	07954 UNUSED SPACE	0	0	0	0	0	194.04	
194.05	07955 MOB	0	0	0	0	0	194.05	
194.06	07956 FOUNDATION	0	0	0	0	0	194.06	
194.07	07957 KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07	
194.08	07958 INDUSTRIAL HEALTH	0	0	0	0	0	194.08	
194.09	07959 COMMUNITY MENTAL HEALTH CENTER	0	522	0	0	0	194.09	
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00	
202.00	TOTAL (sum lines 118 through 201)	376,234	148,858	242,538	208,168	0	202.00	



ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

Period:  
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Cost Center Description	INTERNS & RESIDENTS				PARAMED PRGM-RADIOLOGY	PARAMED PRGM-LAB	
	MENTAL HEALTH OH	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
		17.01	21.00				
<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
4.01 00401	COMMUNICATIONS						4.01
4.02 00402	PURCHASING & RECEIVING						4.02
4.03 00403	REGISTRATION						4.03
4.04 00404	PATIENT ACCOUNTS						4.04
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
17.01 01701	MENTAL HEALTH OH	104,451					17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	358,017				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		35,604			22.00
23.00 02300	PARAMED ED PRGM-RADIOLOGY	0			0		23.00
23.01 02301	PARAMED ED PRGM-LAB	0				2,933	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	0					30.00
31.00 03100	INTENSIVE CARE UNIT	0					31.00
40.00 04000	SUBPROVIDER - I PF	54,774					40.00
41.00 04100	SUBPROVIDER - I RF	0					41.00
43.00 04300	NURSERY	0					43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	0					50.00
51.00 05100	RECOVERY ROOM	0					51.00
51.01 05101	ENDOSCOPY	0					51.01
52.00 05200	DELIVERY ROOM & LABOR ROOM	0					52.00
53.00 05300	ANESTHESIOLOGY	0					53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0					54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0					55.00
60.00 06000	LABORATORY	0					60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0					63.00
65.00 06500	RESPIRATORY THERAPY	0					65.00
66.00 06600	PHYSICAL THERAPY	0					66.00
69.00 06900	ELECTROCARDIOLOGY	0					69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0					70.00
70.01 07001	NEURODIAGNOSTICS	0					70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0					72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0					73.00
75.00 07500	ASC (NON-DISTINCT PART)	0					75.00
76.00 03950	MH ANCILLARY OUTPATIENT	0					76.00
76.01 03951	INPATIENT DIALYSIS	0					76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	0					90.00
90.01 04950	WOUND CLINIC	0					90.01
91.00 09100	EMERGENCY	0					91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0					96.00
101.00 10100	HOME HEALTH AGENCY	0					101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300	INTEREST EXPENSE						113.00
116.00 11600	HOSPICE	0					116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	54,774	0	0	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0					192.00
192.01 19201	FP PETERSBURG	0					192.01
192.02 19202	PEDIATRICS	0					192.02
192.03 19203	WASHINGTON PRIMARY CARE	0					192.03
192.04 19204	FOHC	0					192.04
194.00 07950	COMMUNITY HEALTH SERVICES	0					194.00
194.01 07960	CCBHC GRANTS	0					194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

Period:  
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Cost Center Description	INTERNS & RESIDENTS					
	MENTAL HEALTH	SERVICES-SALAR	SERVICES-OTHER	PARAMED ED	PARAMED ED	
	OH	Y & FRINGES	PRGM COSTS	PRGM-RADIOLOGY	PRGM-LAB	
	17.01	21.00	22.00	23.00	23.01	
194.02 07952 MARKETING AND PUBLIC RELATIONS	0					194.02
194.03 07953 MH RESIDENTIAL	0					194.03
194.04 07954 UNUSED SPACE	0					194.04
194.05 07955 MOB	0					194.05
194.06 07956 FOUNDATION	0					194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	0					194.07
194.08 07958 INDUSTRIAL HEALTH	0					194.08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	49,677					194.09
200.00 Cross Foot Adjustments		358,017	35,604	0	2,933	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	104,451	358,017	35,604	0	2,933	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	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
4.01	00401	COMMUNICATIONS				4.01
4.02	00402	PURCHASING & RECEIVING				4.02
4.03	00403	REGISTRATION				4.03
4.04	00404	PATIENT ACCOUNTS				4.04
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
17.01	01701	MENTAL HEALTH OH				17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY				23.00
23.01	02301	PARAMED ED PRGM-LAB				23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	2,500,030	0	2,500,030	30.00
31.00	03100	INTENSIVE CARE UNIT	910,831	0	910,831	31.00
40.00	04000	SUBPROVIDER - IPF	618,440	0	618,440	40.00
41.00	04100	SUBPROVIDER - IRF	724,646	0	724,646	41.00
43.00	04300	NURSERY	14,868	0	14,868	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	957,880	0	957,880	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
51.01	05101	ENDOSCOPY	467,701	0	467,701	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,223	0	39,223	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	883,828	0	883,828	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	686,122	0	686,122	55.00
60.00	06000	LABORATORY	379,614	0	379,614	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	233,794	0	233,794	65.00
66.00	06600	PHYSICAL THERAPY	609,775	0	609,775	66.00
69.00	06900	ELECTROCARDIOLOGY	701,676	0	701,676	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	285,562	0	285,562	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	192,070	0	192,070	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	105,369	0	105,369	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	337,782	0	337,782	73.00
75.00	07500	ASC (NON-DISTINCT PART)	132,398	0	132,398	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	294,763	0	294,763	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	82,759	0	82,759	90.00
90.01	04950	WOUND CLINIC	125,945	0	125,945	90.01
91.00	09100	EMERGENCY	1,029,265	0	1,029,265	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	15,506	0	15,506	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE	0	0	0	113.00
116.00	11600	HOSPICE	185,045	0	185,045	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,514,892	0	12,514,892	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,760,872	0	4,760,872	192.00
192.01	19201	FP PETERSBURG	130,884	0	130,884	192.01
192.02	19202	PEDIATRICS	19,027	0	19,027	192.02
192.03	19203	WASHINGTON PRIMARY CARE	251,780	0	251,780	192.03
192.04	19204	FOHC	78	0	78	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	17,276	0	17,276	194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
194.01	07960	CCBHC GRANTS	21,899	0	21,899	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	64,152	0	64,152	194.02
194.03	07953	MH RESIDENTIAL	699,975	0	699,975	194.03
194.04	07954	UNUSED SPACE	694,774	0	694,774	194.04
194.05	07955	MOB	231	0	231	194.05
194.06	07956	FOUNDATION	15,896	0	15,896	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	160,716	0	160,716	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	1,307,019	0	1,307,019	194.09
200.00		Cross Foot Adjustments	396,554	0	396,554	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,056,025	0	21,056,025	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

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

Worksheet B-1  
Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	884,498				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		884,498			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,862	4,862	107,647,744		4.00
4.01 00401	COMMUNICATIONS	0	0	283,462	2,255	4.01
4.02 00402	PURCHASING & RECEIVING	11,575	11,575	672,983	20	18,800,370 4.02
4.03 00403	REGISTRATION	11,304	11,304	1,735,815	35	12,541 4.03
4.04 00404	PATIENT ACCOUNTS	0	0	2,628,262	44	10,417 4.04
5.00 00500	ADMINISTRATIVE & GENERAL	47,966	47,966	7,206,764	173	46,874 5.00
7.00 00700	OPERATION OF PLANT	239,930	239,930	2,314,574	120	130,735 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	5,266	5,266	220,992	0	64,643 8.00
9.00 00900	HOUSEKEEPING	7,326	7,326	2,043,150	37	214,527 9.00
10.00 01000	DIETARY	4,314	4,314	597,108	9	404,667 10.00
11.00 01100	CAFETERIA	8,205	8,205	1,135,650	18	769,643 11.00
13.00 01300	NURSING ADMINISTRATION	9,763	9,763	2,288,533	19	649,029 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	3,967	3,967	358,307	7	68,513 14.00
15.00 01500	PHARMACY	5,979	5,979	2,911,308	33	39,075 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	4,580	4,580	3,617,256	52	5,385 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
17.01 01701	MENTAL HEALTH OH	2,605	2,605	475,129	251	8,175 17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	10,144	10,144	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	1,411,338	50	23,365 22.00
23.00 02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0 23.00
23.01 02301	PARAMED ED PRGM-LAB	0	0	240,212	0	4,340 23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	61,220	61,220	5,067,882	159	362,411 30.00
31.00 03100	INTENSIVE CARE UNIT	20,954	20,954	3,272,273	98	332,178 31.00
40.00 04000	SUBPROVIDER - IPF	13,034	13,034	2,052,405	0	25,941 40.00
41.00 04100	SUBPROVIDER - IRF	17,193	17,193	2,034,132	71	92,488 41.00
43.00 04300	NURSERY	0	0	338,753	0	23,876 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	24,026	24,026	3,247,268	149	721,377 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
51.01 05101	ENDOSCOPY	12,237	12,237	730,592	26	422,117 51.01
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	1,016,361	63	86,436 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	21,666	21,666	3,607,006	63	360,010 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	17,985	17,985	2,710,338	36	89,523 55.00
60.00 06000	LABORATORY	7,298	7,298	2,307,337	35	1,291,422 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
65.00 06500	RESPIRATORY THERAPY	5,679	5,679	2,491,029	40	16,973 65.00
66.00 06600	PHYSICAL THERAPY	15,277	15,277	3,851,462	27	47,205 66.00
69.00 06900	ELECTROCARDIOLOGY	18,181	18,181	5,030,178	79	146,591 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
70.01 07001	NEURODIAGNOSTICS	7,708	7,708	422,506	20	97,684 70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	7,095,914 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,560,067 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	1,025,093	0	351,659 75.00
76.00 03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0 76.00
76.01 03951	INPATIENT DIALYSIS	8,582	8,582	0	3	1,955 76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	2,254	2,254	77,480	9	142 90.00
90.01 04950	WOUND CLINIC	2,976	2,976	395,709	10	117,968 90.01
91.00 09100	EMERGENCY	23,669	23,669	4,224,546	105	373,377 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	394	394	93,968	0	10,351 96.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	4,861	4,861	448,702	23	12,237 116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	662,980	662,980	74,585,863	1,884	18,091,831 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	127,997	127,997	21,890,755	362	523,998 192.00
192.01 19201	FP PETERSBURG	3,705	3,705	232,381	0	1,329 192.01
192.02 19202	PEDIATRICS	0	0	1,091,031	0	14,360 192.02
192.03 19203	WASHINGTON PRIMARY CARE	6,800	6,800	1,368,298	0	21,945 192.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

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

Worksheet B-1

Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
192.04 19204 FOHC	0	0	9,660	0	0	192.04
194.00 07950 COMMUNITY HEALTH SERVICES	415	415	101,264	3	4,994	194.00
194.01 07960 CCBHC GRANTS	0	0	1,357,807	0	55,084	194.01
194.02 07952 MARKETING AND PUBLIC RELATIONS	1,690	1,690	235,800	4	217	194.02
194.03 07953 MH RESIDENTIAL	20,260	20,260	485,347	0	29,014	194.03
194.04 07954 UNUSED SPACE	20,370	20,370	0	0	0	194.04
194.05 07955 MOB	0	0	0	0	8	194.05
194.06 07956 FOUNDATION	466	466	0	2	0	194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	4,712	4,712	0	0	0	194.07
194.08 07958 INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	35,103	35,103	6,289,538	0	57,590	194.09
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)	20,960,881	95,144	30,844,796	307,076	1,217,042	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	23.698054	0.107568	0.286535	136.175610	0.064735	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			115,743	305	276,276	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.001075	0.135255	0.014695	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: 15-0042

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

Worksheet B-1  
Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Description		REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		4.03	4.04	5A	5.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
4.01	00401						4.01
4.02	00402						4.02
4.03	00403						4.03
4.04	00404	660,027,621	660,027,621				4.04
5.00	00500	0	0	-18,150,076	209,160,659		5.00
7.00	00700	0	0	0	12,704,262	568,861	7.00
8.00	00800	0	0	0	482,308	5,266	8.00
9.00	00900	0	0	0	3,036,478	7,326	9.00
10.00	01000	0	0	0	1,303,725	4,314	10.00
11.00	01100	0	0	0	1,570,321	8,205	11.00
13.00	01300	0	0	0	4,416,923	9,763	13.00
14.00	01400	0	0	0	763,421	3,967	14.00
15.00	01500	0	0	0	4,157,454	5,979	15.00
16.00	01600	0	0	0	5,185,604	4,580	16.00
17.00	01700	0	0	0	0	0	17.00
17.01	01701	0	0	0	950,148	2,605	17.01
21.00	02100	0	0	0	2,428,483	10,144	21.00
22.00	02200	0	0	0	2,379,862	0	22.00
23.00	02300	0	0	0	0	0	23.00
23.01	02301	0	0	0	295,377	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	29,325,343	29,325,343	0	10,882,079	61,220	30.00
31.00	03100	16,931,150	16,931,150	0	6,640,529	20,954	31.00
40.00	04000	9,327,474	9,327,474	0	2,985,221	13,034	40.00
41.00	04100	8,076,659	8,076,659	0	3,548,857	17,193	41.00
43.00	04300	1,429,086	1,429,086	0	484,750	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	48,724,660	48,724,660	0	5,356,975	24,026	50.00
51.00	05100	0	0	0	0	0	51.00
51.01	05101	11,720,766	11,720,766	0	1,963,598	12,237	51.01
52.00	05200	8,126,068	8,126,068	0	1,536,553	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	101,735,865	101,735,865	0	8,924,254	21,666	54.00
55.00	05500	25,013,062	25,013,062	0	4,317,677	17,985	55.00
60.00	06000	75,006,225	75,006,225	0	8,960,480	7,298	60.00
63.00	06300	0	0	0	0	0	63.00
65.00	06500	14,879,570	14,879,570	0	3,503,703	5,679	65.00
66.00	06600	26,438,823	26,438,823	0	5,791,767	15,277	66.00
69.00	06900	49,703,275	49,703,275	0	4,982,595	18,181	69.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	6,802,876	6,802,876	0	1,604,281	7,708	70.01
71.00	07100	1,911	1,911	0	4,271,547	0	71.00
72.00	07200	0	0	0	3,781,045	0	72.00
73.00	07300	70,139,207	70,139,207	0	17,077,796	0	73.00
75.00	07500	25,919,018	25,919,018	0	2,220,759	0	75.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	1,020,772	1,020,772	0	483,852	8,582	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	89,313	89,313	0	156,837	2,254	90.00
90.01	04950	6,263,026	6,263,026	0	1,327,156	2,976	90.01
91.00	09100	51,742,256	51,742,256	0	7,328,985	23,669	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	407,736	407,736	0	199,815	394	96.00
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
116.00	11600	2,023,096	2,023,096	0	892,126	4,861	116.00
118.00		590,847,237	590,847,237	-18,150,076	148,897,603	347,343	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	53,130,448	53,130,448	0	41,053,733	127,997	192.00
192.01	19201	562,532	562,532	0	595,962	3,705	192.01
192.02	19202	2,871,198	2,871,198	0	1,728,324	0	192.02
192.03	19203	3,158,822	3,158,822	0	2,158,699	6,800	192.03
192.04	19204	0	0	0	12,428	0	192.04
194.00	07950	71,663	71,663	0	175,437	415	194.00
194.01	07960	759,600	759,600	0	2,155,329	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

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

Worksheet B-1

Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Description	REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	4.03	4.04	5A	5.00	7.00	
194.02 07952 MARKETING AND PUBLIC RELATIONS	0	0	0	932,406	1,690	194.02
194.03 07953 MH RESIDENTIAL	167,638	167,638	0	1,162,748	20,260	194.03
194.04 07954 UNUSED SPACE	0	0	0	484,920	20,370	194.04
194.05 07955 MOB	0	0	0	41,972	0	194.05
194.06 07956 FOUNDATION	0	0	0	11,365	466	194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	0	112,172	4,712	194.07
194.08 07958 INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	8,458,483	8,458,483	0	9,637,561	35,103	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	2,564,064	4,988,441		18,150,076	13,806,687	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.003885	0.007558		0.086776	24.270757	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	271,154	2,984		1,150,320	5,785,984	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000411	0.000005		0.005500	10.171174	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: 15-0042

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

Worksheet B-1

Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURSING)	
		8.00	9.00	10.00	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
4.01	00401						4.01
4.02	00402						4.02
4.03	00403						4.03
4.04	00404						4.04
5.00	00500						5.00
7.00	00700						7.00
8.00	00800	845,567					8.00
9.00	00900	53,826	65,207				9.00
10.00	01000	2,852	1,784	32,288			10.00
11.00	01100	5,425	426	0	2,111,064		11.00
13.00	01300	0	0	0	57,320	805,906	13.00
14.00	01400	12,142	756	0	17,979	0	14.00
15.00	01500	0	599	0	68,750	0	15.00
16.00	01600	0	512	0	123,957	0	16.00
17.00	01700	0	0	0	0	0	17.00
17.01	01701	0	1,870	0	13,050	0	17.01
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	966	0	26,420	26,420	22.00
23.00	02300	0	0	0	0	0	23.00
23.01	02301	0	0	0	6,602	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	284,055	16,047	14,970	168,313	160,545	30.00
31.00	03100	70,668	4,489	5,425	92,144	92,144	31.00
40.00	04000	18,662	0	4,801	64,168	63,771	40.00
41.00	04100	50,662	2,862	7,092	65,969	65,969	41.00
43.00	04300	1,923	166	0	9,055	9,055	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	30,687	3,720	0	68,204	50,084	50.00
51.00	05100	0	0	0	0	0	51.00
51.01	05101	23,617	1,008	0	25,275	25,275	51.01
52.00	05200	10,027	219	0	28,649	36,417	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	53,366	2,098	0	104,232	10,664	54.00
55.00	05500	9,023	1,103	0	62,141	43,166	55.00
60.00	06000	0	963	0	96,343	0	60.00
63.00	06300	0	0	0	0	0	63.00
65.00	06500	166	742	0	62,889	0	65.00
66.00	06600	9,183	1,755	0	111,817	36,236	66.00
69.00	06900	19,231	2,183	0	86,744	0	69.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	12,005	660	0	14,888	3,525	70.01
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
75.00	07500	32,332	2,924	0	36,468	36,468	75.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	0	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	1,107	0	2,725	0	90.00
90.01	04950	9,725	350	0	10,726	2,829	90.01
91.00	09100	106,211	4,439	0	120,179	120,179	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	0	0	0	3,510	0	96.00
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
116.00	11600	0	909	0	15,434	15,434	116.00
118.00							118.00
		815,788	54,657	32,288	1,563,951	798,181	
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	29,779	10,167	0	394,444	7,725	192.00
192.01	19201	0	0	0	7,305	0	192.01
192.02	19202	0	0	0	25,976	0	192.02
192.03	19203	0	0	0	32,329	0	192.03
192.04	19204	0	0	0	0	0	192.04
194.00	07950	0	328	0	3,659	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

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

Worksheet B-1

Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURSING)	
		8.00	9.00	10.00	11.00	13.00	
194.01	07960 CCBHC GRANTS	0	0	0	48,369	0	194.01
194.02	07952 MARKETING AND PUBLIC RELATIONS	0	55	0	7,704	0	194.02
194.03	07953 MH RESIDENTIAL	0	0	0	27,327	0	194.03
194.04	07954 UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955 MOB	0	0	0	0	0	194.05
194.06	07956 FOUNDATION	0	0	0	0	0	194.06
194.07	07957 KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958 INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959 COMMUNITY MENTAL HEALTH CENTER	0	0	0	0	0	194.09
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)	651,971	3,519,281	1,620,044	1,932,904	5,089,644	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.771046	53.970908	50.174802	0.915607	6.315431	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	182,762	282,602	168,683	302,969	376,234	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.216141	4.333921	5.224325	0.143515	0.466846	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: 15-0042

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

Worksheet B-1  
Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Description			CENTRAL SERVICES & SUPPLY (SUPPLIES COST)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (NET CHARGES)	MENTAL HEALTH OH (NET CHARGES)	
			14.00	15.00	16.00	17.00	17.01	
<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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
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	16,428,781					14.00
15.00	01500	PHARMACY	39,075	18,826,607				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,385	0	830			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
17.01	01701	MENTAL HEALTH OH	8,175	0	0	0	17,785,957	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	23,365	9,514	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	4,340	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	362,411	274	102	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	332,178	58	98	0	0	31.00
40.00	04000	SUBPROVIDER - I PF	25,941	24	118	0	9,327,474	40.00
41.00	04100	SUBPROVIDER - IRF	92,488	12	50	0	0	41.00
43.00	04300	NURSERY	23,876	159	16	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	721,377	15,490	60	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	422,117	41,388	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	86,436	537	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	360,010	288,211	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	89,523	3,880	0	0	0	55.00
60.00	06000	LABORATORY	1,291,422	72	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	16,973	1,277	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	47,205	2,958	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	146,591	69,544	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	97,684	22	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,095,914	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,560,067	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,663,994	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	351,659	26,406	230	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	1,955	3,197	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	142	17	0	0	0	90.00
90.01	04950	WOUND CLINIC	117,968	15,739	20	0	0	90.01
91.00	09100	EMERGENCY	373,377	11,894	136	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	10,351	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	12,237	29	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,720,242	17,154,696	830	0	9,327,474	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	523,998	1,346,390	0	0	0	192.00
192.01	19201	FP PETERSBURG	1,329	12,270	0	0	0	192.01
192.02	19202	PEDIATRICS	14,360	239,439	0	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	21,945	71,304	0	0	0	192.03
192.04	19204	FOHC	0	0	0	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	4,994	510	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

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

Worksheet B-1

Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Description			CENTRAL SERVICES & SUPPLIES (SUPPLIES COST)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (NET CHARGES)	MENTAL HEALTH OH (NET CHARGES)	
			14.00	15.00	16.00	17.00	17.01	
194.01	07960	CCBHC GRANTS	55,084	1,490	0	0	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	217	0	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	29,014	506	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	8	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	57,590	2	0	0	8,458,483	194.09
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)	992,576	4,760,974	5,888,204	0	1,209,192	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.060417	0.252885	7,094.221687	0.000000	0.067986	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	148,858	242,538	208,168	0	104,451	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009061	0.012883	250.804819	0.000000	0.005873	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: 15-0042

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

Worksheet B-1

Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Description	INTERNS & RESIDENTS				PARAMED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED PRGM-LAB (ASSIGNED TIME)	
	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)					
	21.00	22.00	23.00	23.01			
<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
4.01 00401	COMMUNICATIONS						4.01
4.02 00402	PURCHASING & RECEIVING						4.02
4.03 00403	REGISTRATION						4.03
4.04 00404	PATIENT ACCOUNTS						4.04
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
17.01 01701	MENTAL HEALTH OH						17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	8,762					21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		8,762				22.00
23.00 02300	PARAMED PRGM-RADIOLOGY			100			23.00
23.01 02301	PARAMED PRGM-LAB				100		23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	2,745	2,745	0	0		30.00
31.00 03100	INTENSIVE CARE UNIT	537	537	0	0		31.00
40.00 04000	SUBPROVIDER - IPF	1,533	1,533	0	0		40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00 04300	NURSERY	0	0	0	0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	0	0	0	0		50.00
51.00 05100	RECOVERY ROOM	0	0	0	0		51.00
51.01 05101	ENDOSCOPY	0	0	0	0		51.01
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	100	0		54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	56	56	0	0		55.00
60.00 06000	LABORATORY	0	0	0	100		60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
65.00 06500	RESPIRATORY THERAPY	156	156	0	0		65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0		66.00
69.00 06900	ELECTROCARDIOLOGY	336	336	0	0		69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
70.01 07001	NEURODIAGNOSTICS	0	0	0	0		70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00 07500	ASC (NON-DISTINCT PART)	1,492	1,492	0	0		75.00
76.00 03950	MH ANCILLARY OUTPATIENT	0	0	0	0		76.00
76.01 03951	INPATIENT DIALYSIS	180	180	0	0		76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	0	0	0	0		90.00
90.01 04950	WOUND CLINIC	0	0	0	0		90.01
91.00 09100	EMERGENCY	457	457	0	0		91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300	INTEREST EXPENSE						113.00
116.00 11600	HOSPICE			0	0		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	7,492	7,492	100	100		118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	644	644	0	0		192.00
192.01 19201	FP PETERSBURG	0	0	0	0		192.01
192.02 19202	PEDIATRICS	0	0	0	0		192.02
192.03 19203	WASHINGTON PRIMARY CARE	0	0	0	0		192.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

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

Worksheet B-1

Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Description		INTERNS & RESIDENTS		PARAMED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED PRGM-LAB (ASSIGNED TIME)		
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)				
		21.00	22.00				
192.04	19204	FOHC	0	0	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	0	194.00
194.01	07960	CCBHC GRANTS	0	0	0	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	626	626	0	0	194.09
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,885,420	2,833,375	0	327,316	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	329.310660	323.370806	0.000000	3,273.160000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	358,017	35,604	0	2,933	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	40.860192	4.063456	0.000000	29.330000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0	0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000	0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0042

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	Hospital			
					RCE Disallowance	Total Costs		PPS
		1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	17,062,041		17,062,041	0	17,062,041	30.00
31.00	03100	INTENSIVE CARE UNIT	9,675,913		9,675,913	0	9,675,913	31.00
40.00	04000	SUBPROVIDER - I PF	5,750,209		5,750,209	30,596	5,780,805	40.00
41.00	04100	SUBPROVIDER - I RF	5,660,795		5,660,795	0	5,660,795	41.00
43.00	04300	NURSERY	717,725		717,725	0	717,725	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	7,481,297		7,481,297	0	7,481,297	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
51.01	05101	ENDOSCOPY	2,722,339		2,722,339	0	2,722,339	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,951,018		1,951,018	0	1,951,018	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,636,313		10,636,313	0	10,636,313	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,531,244		5,531,244	13,484	5,544,728	55.00
60.00	06000	LABORATORY	10,460,707		10,460,707	0	10,460,707	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	4,044,678	0	4,044,678	0	4,044,678	65.00
66.00	06600	PHYSICAL THERAPY	7,101,763	0	7,101,763	0	7,101,763	66.00
69.00	06900	ELECTROCARDIOLOGY	6,094,745		6,094,745	0	6,094,745	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	2,017,252		2,017,252	5,315	2,022,567	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,070,928		5,070,928	0	5,070,928	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,324,238		4,324,238	0	4,324,238	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,773,820		22,773,820	0	22,773,820	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,519,504		4,519,504	5,815	4,525,319	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0		0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	735,057		735,057	0	735,057	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	287,407		287,407	0	287,407	90.00
90.01	04950	WOUND CLINIC	1,721,617		1,721,617	0	1,721,617	90.01
91.00	09100	EMERGENCY	10,720,300		10,720,300	0	10,720,300	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,868,666		3,868,666	0	3,868,666	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	230,556		230,556	0	230,556	96.00
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,248,930		1,248,930		1,248,930	116.00
200.00		Subtotal (see instructions)	152,409,062	0	152,409,062	55,210	152,464,272	200.00
201.00		Less Observation Beds	3,868,666		3,868,666		3,868,666	201.00
202.00		Total (see instructions)	148,540,396	0	148,540,396	55,210	148,595,606	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0042		Period: From 01/01/2021 To 12/31/2021		Worksheet C Part I Date/Time Prepared: 5/26/2022 9:38 am	
			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	18,452,500		18,452,500			30.00
31.00	03100	INTENSIVE CARE UNIT	13,997,030		13,997,030			31.00
40.00	04000	SUBPROVIDER - IPF	9,296,440		9,296,440			40.00
41.00	04100	SUBPROVIDER - IRF	7,970,834		7,970,834			41.00
43.00	04300	NURSERY	1,403,774		1,403,774			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	13,507,018	26,011,744	39,518,762	0.189310	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
51.01	05101	ENDOSCOPY	979,209	10,488,290	11,467,499	0.237396	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,871,505	308,823	6,180,328	0.315682	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,022,264	82,653,604	98,675,868	0.107790	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	368,780	24,379,841	24,748,621	0.223497	0.000000	55.00
60.00	06000	LABORATORY	22,216,844	52,789,381	75,006,225	0.139465	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	8,738,223	4,085,004	12,823,227	0.315418	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	15,614,633	10,815,645	26,430,278	0.268698	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	13,434,636	26,550,858	39,985,494	0.152424	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	255,242	6,107,581	6,362,823	0.317037	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,171,479	1,947,719	4,119,198	1.231047	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,046,741	7,739,076	10,785,817	0.400919	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,633,924	55,546,252	75,180,176	0.302923	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	65,408	23,843,663	23,909,071	0.189029	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0.000000	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	968,719	52,053	1,020,772	0.720099	0.000000	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	89,313	89,313	3.217975	0.000000	90.00
90.01	04950	WOUND CLINIC	56,530	4,190,382	4,246,912	0.405381	0.000000	90.01
91.00	09100	EMERGENCY	10,325,707	41,358,211	51,683,918	0.207420	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,496,804	9,877,951	15,374,755	0.251625	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	407,736	407,736	0.565454	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,023,096	2,023,096			116.00
200.00		Subtotal (see instructions)	189,894,244	391,266,223	581,160,467			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	189,894,244	391,266,223	581,160,467			202.00



COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/26/2022 9:38 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - I PF			40.00
41.00	04100 SUBPROVIDER - I RF			41.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.189310		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
51.01	05101 ENDOSCOPY	0.237396		51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.315682		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.107790		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.224042		55.00
60.00	06000 LABORATORY	0.139465		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500 RESPIRATORY THERAPY	0.315418		65.00
66.00	06600 PHYSICAL THERAPY	0.268698		66.00
69.00	06900 ELECTROCARDIOLOGY	0.152424		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001 NEURODIAGNOSTICS	0.317873		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.231047		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.400919		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.302923		73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.189272		75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0.000000		76.00
76.01	03951 INPATIENT DIALYSIS	0.720099		76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	3.217975		90.00
90.01	04950 WOUND CLINIC	0.405381		90.01
91.00	09100 EMERGENCY	0.207420		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.251625		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.565454		96.00
101.00	10100 HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
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: 15-0042

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/26/2022 9:38 am

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	17,062,041	17,062,041	0	17,062,041	30.00
31.00	03100 INTENSIVE CARE UNIT	9,675,913	9,675,913	0	9,675,913	31.00
40.00	04000 SUBPROVIDER - I/PF	5,750,209	5,750,209	30,596	5,780,805	40.00
41.00	04100 SUBPROVIDER - I/RP	5,660,795	5,660,795	0	5,660,795	41.00
43.00	04300 NURSERY	717,725	717,725	0	717,725	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	7,481,297	7,481,297	0	7,481,297	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	51.00
51.01	05101 ENDOSCOPY	2,722,339	2,722,339	0	2,722,339	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,951,018	1,951,018	0	1,951,018	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	10,636,313	10,636,313	0	10,636,313	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	5,531,244	5,531,244	13,484	5,544,728	55.00
60.00	06000 LABORATORY	10,460,707	10,460,707	0	10,460,707	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	4,044,678	4,044,678	0	4,044,678	65.00
66.00	06600 PHYSICAL THERAPY	7,101,763	7,101,763	0	7,101,763	66.00
69.00	06900 ELECTROCARDIOLOGY	6,094,745	6,094,745	0	6,094,745	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	2,017,252	2,017,252	5,315	2,022,567	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,070,928	5,070,928	0	5,070,928	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4,324,238	4,324,238	0	4,324,238	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	22,773,820	22,773,820	0	22,773,820	73.00
75.00	07500 ASC (NON-DISTINCT PART)	4,519,504	4,519,504	5,815	4,525,319	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	0	0	76.00
76.01	03951 INPATIENT DIALYSIS	735,057	735,057	0	735,057	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	287,407	287,407	0	287,407	90.00
90.01	04950 WOUND CLINIC	1,721,617	1,721,617	0	1,721,617	90.01
91.00	09100 EMERGENCY	10,720,300	10,720,300	0	10,720,300	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,868,666	3,868,666	0	3,868,666	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	230,556	230,556	0	230,556	96.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
116.00	11600 HOSPICE	1,248,930	1,248,930		1,248,930	116.00
200.00	Subtotal (see instructions)	152,409,062	152,409,062	55,210	152,464,272	200.00
201.00	Less Observation Beds	3,868,666	3,868,666		3,868,666	201.00
202.00	Total (see instructions)	148,540,396	148,540,396	55,210	148,595,606	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0042

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX Hospital Cost							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	18,452,500		18,452,500		30.00
31.00	03100	INTENSIVE CARE UNIT	13,997,030		13,997,030		31.00
40.00	04000	SUBPROVIDER - IPF	9,296,440		9,296,440		40.00
41.00	04100	SUBPROVIDER - IRF	7,970,834		7,970,834		41.00
43.00	04300	NURSERY	1,403,774		1,403,774		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	13,507,018	26,011,744	39,518,762	0.189310	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	979,209	10,488,290	11,467,499	0.237396	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,871,505	308,823	6,180,328	0.315682	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,022,264	82,653,604	98,675,868	0.107790	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	368,780	24,379,841	24,748,621	0.223497	55.00
60.00	06000	LABORATORY	22,216,844	52,789,381	75,006,225	0.139465	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	8,738,223	4,085,004	12,823,227	0.315418	65.00
66.00	06600	PHYSICAL THERAPY	15,614,633	10,815,645	26,430,278	0.268698	66.00
69.00	06900	ELECTROCARDIOLOGY	13,434,636	26,550,858	39,985,494	0.152424	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	255,242	6,107,581	6,362,823	0.317037	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,171,479	1,947,719	4,119,198	1.231047	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,046,741	7,739,076	10,785,817	0.400919	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,633,924	55,546,252	75,180,176	0.302923	73.00
75.00	07500	ASC (NON-DISTINCT PART)	65,408	23,843,663	23,909,071	0.189029	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	968,719	52,053	1,020,772	0.720099	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	89,313	89,313	3.217975	90.00
90.01	04950	WOUND CLINIC	56,530	4,190,382	4,246,912	0.405381	90.01
91.00	09100	EMERGENCY	10,325,707	41,358,211	51,683,918	0.207420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,496,804	9,877,951	15,374,755	0.251625	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	407,736	407,736	0.565454	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	2,023,096	2,023,096		116.00
200.00		Subtotal (see instructions)	189,894,244	391,266,223	581,160,467		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	189,894,244	391,266,223	581,160,467		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/26/2022 9:38 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
51.01	05101 ENDOSCOPY	0.000000		51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
60.00	06000 LABORATORY	0.000000		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001 NEURODIAGNOSTICS	0.000000		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0.000000		76.00
76.01	03951 INPATIENT DIALYSIS	0.000000		76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
90.01	04950 WOUND CLINIC	0.000000		90.01
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
101.00	10100 HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Prepared: 5/26/2022 9:38 am
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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	2,500,030	0	2,500,030	14,091	177.42	30.00
31.00	INTENSIVE CARE UNIT	910,831	0	910,831	5,425	167.90	31.00
40.00	SUBPROVIDER - IPF	618,440	0	618,440	4,801	128.81	40.00
41.00	SUBPROVIDER - IRF	724,646	0	724,646	7,092	102.18	41.00
43.00	NURSERY	14,868	0	14,868	942	15.78	43.00
200.00	Total (lines 30 through 199)	4,768,815		4,768,815	32,351		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	5,049	895,794				30.00
31.00	INTENSIVE CARE UNIT	2,552	428,481				31.00
40.00	SUBPROVIDER - IPF	933	120,180				40.00
41.00	SUBPROVIDER - IRF	5,223	533,686				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	13,757	1,978,141				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Prepared: 5/26/2022 9:38 am
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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	957,880	39,518,762	0.024239	6,778,401	164,302	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101 ENDOSCOPY	467,701	11,467,499	0.040785	442,882	18,063	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	39,223	6,180,328	0.006346	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	883,828	98,675,868	0.008957	7,732,147	69,257	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	686,122	24,748,621	0.027724	298,789	8,284	55.00
60.00	06000 LABORATORY	379,614	75,006,225	0.005061	9,911,276	50,161	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	233,794	12,823,227	0.018232	2,947,393	53,737	65.00
66.00	06600 PHYSICAL THERAPY	609,775	26,430,278	0.023071	3,082,001	71,105	66.00
69.00	06900 ELECTROCARDIOLOGY	701,676	39,985,494	0.017548	6,647,669	116,653	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	285,562	6,362,823	0.044880	30,032	1,348	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	192,070	4,119,198	0.046628	1,040,758	48,528	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	105,369	10,785,817	0.009769	1,845,947	18,033	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	337,782	75,180,176	0.004493	7,568,532	34,005	73.00
75.00	07500 ASC (NON-DISTINCT PART)	132,398	23,909,071	0.005538	5,168	29	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951 INPATIENT DIALYSIS	294,763	1,020,772	0.288765	455,722	131,597	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	82,759	89,313	0.926618	0	0	90.00
90.01	04950 WOUND CLINIC	125,945	4,246,912	0.029656	9,903	294	90.01
91.00	09100 EMERGENCY	1,029,265	51,683,918	0.019915	4,196,372	83,571	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	566,860	15,374,755	0.036870	2,765,740	101,973	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	15,506	407,736	0.038030	0	0	96.00
200.00	Total (lines 50 through 199)	8,127,892	528,016,793		55,758,732	970,940	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Prepared: 5/26/2022 9:38 am
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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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
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	14,091	0.00	5,049 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	5,425	0.00	2,552 31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,801	0.00	933 40.00
41.00	04100	SUBPROVIDER - IRF	0	0	7,092	0.00	5,223 41.00
43.00	04300	NURSERY	0	0	942	0.00	0 43.00
200.00		Total (lines 30 through 199)	0	0	32,351		13,757 200.00
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
40.00	04000	SUBPROVIDER - IPF	0				40.00
41.00	04100	SUBPROVIDER - IRF	0				41.00
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: 15-0042

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Description		Title XVIII			Hospital		PPS	
		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
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	327,316	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	90.01
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
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	327,316	200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Title XVIII		Hospital		
					Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	PPS		
		4.00	5.00	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	39,518,762	0.000000	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00	
51.01	05101	ENDOSCOPY	0	0	0	11,467,499	0.000000	51.01	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6,180,328	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	98,675,868	0.000000	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	24,748,621	0.000000	55.00	
60.00	06000	LABORATORY	0	327,316	327,316	75,006,225	0.004364	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,823,227	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	26,430,278	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	39,985,494	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00	
70.01	07001	NEURODIAGNOSTICS	0	0	0	6,362,823	0.000000	70.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,119,198	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,785,817	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	75,180,176	0.000000	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	23,909,071	0.000000	75.00	
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00	
76.01	03951	INPATIENT DIALYSIS	0	0	0	1,020,772	0.000000	76.01	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	89,313	0.000000	90.00	
90.01	04950	WOUND CLINIC	0	0	0	4,246,912	0.000000	90.01	
91.00	09100	EMERGENCY	0	0	0	51,683,918	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	15,374,755	0.000000	92.00	
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	407,736	0.000000	96.00	
200.00		Total (lines 50 through 199)	0	327,316	327,316	528,016,793		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/26/2022 9:38 am

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	6,778,401	0	9,091,878	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101 ENDOSCOPY	0.000000	442,882	0	3,567,427	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	10,694	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	7,732,147	0	28,740,085	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	298,789	0	11,682,653	0	55.00
60.00	06000 LABORATORY	0.004364	9,911,276	43,253	6,706,557	29,267	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	2,947,393	0	1,369,945	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	3,082,001	0	243,748	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	6,647,669	0	10,875,928	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0.000000	30,032	0	1,790,585	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,040,758	0	909,357	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,845,947	0	3,639,126	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	7,568,532	0	27,393,530	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	5,168	0	6,555,232	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951 INPATIENT DIALYSIS	0.000000	455,722	0	29,480	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 WOUND CLINIC	0.000000	9,903	0	2,536,728	0	90.01
91.00	09100 EMERGENCY	0.000000	4,196,372	0	9,006,504	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,765,740	0	2,509,108	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00	Total (lines 50 through 199)		55,758,732	43,253	126,658,565	29,267	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/26/2022 9:38 am
		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	0.189310	9,091,878	0	0	1,721,183 50.00
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0 51.00
51.01 05101 ENDOSCOPY	0.237396	3,567,427	0	0	846,893 51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.315682	10,694	0	0	3,376 52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.107790	28,740,085	0	0	3,097,894 54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.223497	11,682,653	0	0	2,611,038 55.00
60.00 06000 LABORATORY	0.139465	6,706,557	0	0	935,330 60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0 63.00
65.00 06500 RESPIRATORY THERAPY	0.315418	1,369,945	0	0	432,105 65.00
66.00 06600 PHYSICAL THERAPY	0.268698	243,748	0	0	65,495 66.00
69.00 06900 ELECTROCARDIOLOGY	0.152424	10,875,928	0	0	1,657,752 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0 70.00
70.01 07001 NEURODIAGNOSTICS	0.317037	1,790,585	0	0	567,682 70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.231047	909,357	0	0	1,119,461 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.400919	3,639,126	0	0	1,458,995 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.302923	27,393,530	0	27,869	8,298,130 73.00
75.00 07500 ASC (NON-DISTINCT PART)	0.189029	6,555,232	0	0	1,239,129 75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0 76.00
76.01 03951 INPATIENT DIALYSIS	0.720099	29,480	0	0	21,229 76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	3.217975	0	0	0	0 90.00
90.01 04950 WOUND CLINIC	0.405381	2,536,728	0	0	1,028,341 90.01
91.00 09100 EMERGENCY	0.207420	9,006,504	0	0	1,868,129 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.251625	2,509,108	0	0	631,354 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.565454	0	0	0	0 96.00
200.00		Subtotal (see instructions)	126,658,565	0	27,869 200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0	0 201.00
202.00		Net Charges (line 200 - line 201)	126,658,565	0	27,869 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/26/2022 9:38 am
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
51.01	05101 ENDOSCOPY	0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000 LABORATORY	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8,442	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	76.00
76.01	03951 INPATIENT DIALYSIS	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
90.01	04950 WOUND CLINIC	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00	Subtotal (see instructions)	0	8,442	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	8,442	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0042 Component CCN: 15-S042		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part II Date/Time Prepared: 5/26/2022 9:38 am		
				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	957,880	39,518,762	0.024239	22,151	537	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	467,701	11,467,499	0.040785	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,223	6,180,328	0.006346	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	883,828	98,675,868	0.008957	55,591	498	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	686,122	24,748,621	0.027724	0	0	55.00
60.00	06000	LABORATORY	379,614	75,006,225	0.005061	199,468	1,010	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	233,794	12,823,227	0.018232	134,188	2,447	65.00
66.00	06600	PHYSICAL THERAPY	609,775	26,430,278	0.023071	29,710	685	66.00
69.00	06900	ELECTROCARDIOLOGY	701,676	39,985,494	0.017548	17,589	309	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	285,562	6,362,823	0.044880	11,672	524	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	192,070	4,119,198	0.046628	2,436	114	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	105,369	10,785,817	0.009769	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	337,782	75,180,176	0.004493	188,739	848	73.00
75.00	07500	ASC (NON-DISTINCT PART)	132,398	23,909,071	0.005538	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	294,763	1,020,772	0.288765	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	82,759	89,313	0.926618	0	0	90.00
90.01	04950	WOUND CLINIC	125,945	4,246,912	0.029656	0	0	90.01
91.00	09100	EMERGENCY	1,029,265	51,683,918	0.019915	253,344	5,045	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	15,374,755	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	15,506	407,736	0.038030	0	0	96.00
200.00		Total (lines 50 through 199)	7,561,032	528,016,793		914,888	12,017	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/26/2022 9:38 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
<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
51.01	05101 ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000 LABORATORY	0	0	0	0	327,316	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951 INPATIENT DIALYSIS	0	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	04950 WOUND CLINIC	0	0	0	0	0	90.01
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
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00	Total (lines 50 through 199)	0	0	0	0	327,316	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/26/2022 9:38 am
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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	39,518,762	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101 ENDOSCOPY	0	0	0	11,467,499	0.000000	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	6,180,328	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	98,675,868	0.000000	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	24,748,621	0.000000	55.00
60.00	06000 LABORATORY	0	327,316	327,316	75,006,225	0.004364	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	12,823,227	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	26,430,278	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	39,985,494	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001 NEURODIAGNOSTICS	0	0	0	6,362,823	0.000000	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,119,198	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,785,817	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	75,180,176	0.000000	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	23,909,071	0.000000	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03951 INPATIENT DIALYSIS	0	0	0	1,020,772	0.000000	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	89,313	0.000000	90.00
90.01	04950 WOUND CLINIC	0	0	0	4,246,912	0.000000	90.01
91.00	09100 EMERGENCY	0	0	0	51,683,918	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	15,374,755	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	407,736	0.000000	96.00
200.00	Total (lines 50 through 199)	0	327,316	327,316	528,016,793		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/26/2022 9:38 am
	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	22,151	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101 ENDOSCOPY	0.000000	0	0	0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	55,591	0	3,214	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000 LABORATORY	0.004364	199,468	870	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	134,188	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	29,710	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	17,589	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0.000000	11,672	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,436	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	188,739	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951 INPATIENT DIALYSIS	0.000000	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 WOUND CLINIC	0.000000	0	0	0	0	90.01
91.00	09100 EMERGENCY	0.000000	253,344	0	3,363	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00	Total (lines 50 through 199)		914,888	870	6,577	0	200.00



APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/26/2022 9:38 am
		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	0.189310	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.237396	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.315682	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107790	3,214	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.223497	0	0	0	55.00
60.00	06000	LABORATORY	0.139465	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.315418	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.268698	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.152424	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.317037	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.231047	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.400919	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302923	0	0	434	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.189029	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.720099	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	3.217975	0	0	0	90.00
90.01	04950	WOUND CLINIC	0.405381	0	0	0	90.01
91.00	09100	EMERGENCY	0.207420	3,363	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.251625	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.565454	0	0	0	96.00
200.00		Subtotal (see instructions)		6,577	0	434	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 - line 201)		6,577	0	434	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/26/2022 9:38 am
	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
51.01 05101 ENDOSCOPY	0	0		51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00 06000 LABORATORY	0	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01 07001 NEURODIAGNOSTICS	0	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	131		73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0	0		76.00
76.01 03951 INPATIENT DIALYSIS	0	0		76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
90.01 04950 WOUND CLINIC	0	0		90.01
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Subtotal (see instructions)	0	131		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	131		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 15-0042 Component CCN: 15-T042		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part II Date/Time Prepared: 5/26/2022 9:38 am	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	957,880	39,518,762	0.024239	125,469	3,041	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	467,701	11,467,499	0.040785	15,318	625	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,223	6,180,328	0.006346	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	883,828	98,675,868	0.008957	506,805	4,539	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	686,122	24,748,621	0.027724	237	7	55.00
60.00	06000	LABORATORY	379,614	75,006,225	0.005061	909,678	4,604	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	233,794	12,823,227	0.018232	523,334	9,541	65.00
66.00	06600	PHYSICAL THERAPY	609,775	26,430,278	0.023071	7,362,828	169,868	66.00
69.00	06900	ELECTROCARDIOLOGY	701,676	39,985,494	0.017548	117,991	2,071	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	285,562	6,362,823	0.044880	11,322	508	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	192,070	4,119,198	0.046628	105,830	4,935	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	105,369	10,785,817	0.009769	19,163	187	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	337,782	75,180,176	0.004493	1,170,936	5,261	73.00
75.00	07500	ASC (NON-DISTINCT PART)	132,398	23,909,071	0.005538	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	294,763	1,020,772	0.288765	164,508	47,504	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	82,759	89,313	0.926618	0	0	90.00
90.01	04950	WOUND CLINIC	125,945	4,246,912	0.029656	0	0	90.01
91.00	09100	EMERGENCY	1,029,265	51,683,918	0.019915	246,894	4,917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	15,374,755	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	15,506	407,736	0.038030	0	0	96.00
200.00		Total (lines 50 through 199)	7,561,032	528,016,793		11,280,313	257,608	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/26/2022 9:38 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
<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
51.01	05101 ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000 LABORATORY	0	0	0	0	327,316	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951 INPATIENT DIALYSIS	0	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	04950 WOUND CLINIC	0	0	0	0	0	90.01
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
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00	Total (lines 50 through 199)	0	0	0	0	327,316	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/26/2022 9:38 am
Title XVIII		Subprovider - IRF	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	39,518,762	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	11,467,499	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6,180,328	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	98,675,868	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	24,748,621	0.000000	55.00
60.00	06000	LABORATORY	0	327,316	327,316	75,006,225	0.004364	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,823,227	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	26,430,278	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	39,985,494	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	6,362,823	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,119,198	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,785,817	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	75,180,176	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	23,909,071	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	1,020,772	0.000000	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	89,313	0.000000	90.00
90.01	04950	WOUND CLINIC	0	0	0	4,246,912	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	51,683,918	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	15,374,755	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	407,736	0.000000	96.00
200.00		Total (lines 50 through 199)	0	327,316	327,316	528,016,793		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/26/2022 9:38 am
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	Title XVIII	Subprovider - IRF	PPS
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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	125,469	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101 ENDOSCOPY	0.000000	15,318	0	0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	506,805	0	2,515	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	237	0	0	0	55.00
60.00	06000 LABORATORY	0.004364	909,678	3,970	943	4	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	523,334	0	230	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	7,362,828	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	117,991	0	474	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0.000000	11,322	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	105,830	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	19,163	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	1,170,936	0	224	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951 INPATIENT DIALYSIS	0.000000	164,508	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 WOUND CLINIC	0.000000	0	0	0	0	90.01
91.00	09100 EMERGENCY	0.000000	246,894	0	2,699	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00	Total (lines 50 through 199)		11,280,313	3,970	7,085	4	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/26/2022 9:38 am
	Title XVIII	Subprovider - IRF	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	0.189310	0	0	0	0	50.00	
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00	
51.01 05101 ENDOSCOPY	0.237396	0	0	0	0	51.01	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.315682	0	0	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.107790	2,515	0	0	271	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	0.223497	0	0	0	0	55.00	
60.00 06000 LABORATORY	0.139465	943	0	0	132	60.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00	
65.00 06500 RESPIRATORY THERAPY	0.315418	230	0	0	73	65.00	
66.00 06600 PHYSICAL THERAPY	0.268698	0	0	0	0	66.00	
69.00 06900 ELECTROCARDIOLOGY	0.152424	474	0	0	72	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00	
70.01 07001 NEURODIAGNOSTICS	0.317037	0	0	0	0	70.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.231047	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.400919	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.302923	224	0	550	68	73.00	
75.00 07500 ASC (NON-DISTINCT PART)	0.189029	0	0	0	0	75.00	
76.00 03950 MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00	
76.01 03951 INPATIENT DIALYSIS	0.720099	0	0	0	0	76.01	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	3.217975	0	0	0	0	90.00	
90.01 04950 WOUND CLINIC	0.405381	0	0	0	0	90.01	
91.00 09100 EMERGENCY	0.207420	2,699	0	0	560	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.251625	0	0	0	0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.565454	0	0	0	0	96.00	
200.00	Subtotal (see instructions)		7,085	550	1,176	200.00	
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00	
202.00	Net Charges (line 200 - line 201)		7,085	0	550	1,176	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/26/2022 9:38 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
51.01 05101 ENDOSCOPY	0	0	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00 06000 LABORATORY	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01 07001 NEURODIAGNOSTICS	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	167	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0	0	76.00
76.01 03951 INPATIENT DIALYSIS	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00 09000 CLINIC	0	0	90.00
90.01 04950 WOUND CLINIC	0	0	90.01
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00 Subtotal (see instructions)	0	167	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	167	202.00



COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/26/2022 9:38 am
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)		14,091	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,091	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)		10,896	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)		5,049	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)		17,062,041	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)		17,062,041	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)		17,062,041	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)		1,210.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,113,582	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		6,113,582	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/26/2022 9:38 am	
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)	PPS
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units		0	0	0.00	0	0	
43.00	INTENSIVE CARE UNIT	9,675,913	5,425	1,783.58	2,552	4,551,696	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					12,665,097	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					23,330,375	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,324,275	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,014,193	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,338,468	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					20,991,907	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)					3,195	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,210.85	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,868,666	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/26/2022 9:38 am	
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	2,500,030	17,062,041	0.146526	3,868,666	566,860	90.00
91.00	Nursing Program cost	0	17,062,041	0.000000	3,868,666	0	91.00
92.00	Allied health cost	0	17,062,041	0.000000	3,868,666	0	92.00
93.00	All other Medical Education	0	17,062,041	0.000000	3,868,666	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/26/2022 9:38 am
		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)			4,801 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,801 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)			4,801 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)			933 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)			5,780,805 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			5,780,805 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)			5,780,805 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)			1,204.08 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,123,407 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,123,407 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-S042		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/26/2022 9:38 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	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	OTHER SPECIAL CARE (SPECIFY)						47.00
<b>Cost Center Description</b>							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				207,424		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				1,330,831		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)				120,180		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				12,887		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				133,067		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)				1,197,764		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: 15-0042 Component CCN: 15-S042		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/26/2022 9:38 am	
		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	618,440	5,780,805	0.106982	0	0	90.00
91.00	Nursing Program cost	0	5,780,805	0.000000	0	0	91.00
92.00	Allied health cost	0	5,780,805	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,780,805	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/26/2022 9:38 am
		Title XVIII	Subprovider - IRF	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)			7,092 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			7,092 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)			7,092 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)			5,223 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)			5,660,795 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			5,660,795 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)			5,660,795 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)			798.19 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			4,168,946 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)			4,168,946 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-T042		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/26/2022 9:38 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	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	OTHER SPECIAL CARE (SPECIFY)						47.00
<b>Cost Center Description</b>							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				3,036,310		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				7,205,256		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)				533,686		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				261,578		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				795,264		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				6,409,992		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: 15-0042 Component CCN: 15-T042		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/26/2022 9:38 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	724,646	5,660,795	0.128011	0	0	90.00
91.00	Nursing Program cost	0	5,660,795	0.000000	0	0	91.00
92.00	Allied health cost	0	5,660,795	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,660,795	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/26/2022 9:38 am
Cost Center Description			Cost	
			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)		14,091	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,091	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)		10,896	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)		461	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)		942	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)		17,062,041	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)		17,062,041	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)		17,062,041	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)		1,210.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		558,202	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)		558,202	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1	
		Title XIX		Hospital		Date/Time Prepared: 5/26/2022 9:38 am	
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)	717,725	942	761.92	0	0	
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	9,675,913	5,425	1,783.58	0	0	
44.00	CORONARY CARE UNIT						
45.00	BURN INTENSIVE CARE UNIT						
46.00	SURGICAL INTENSIVE CARE UNIT						
47.00	OTHER SPECIAL CARE (SPECIFY)						
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					569,403	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,127,605	
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	
55.00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	
58.00	Bonus payment (see instructions)					0	
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	
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	
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	
62.00	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	
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	
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	
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	
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	
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	
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)					3,195	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,210.85	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,868,666	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/26/2022 9:38 am	
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	2,500,030	17,062,041	0.146526	3,868,666	566,860	90.00
91.00	Nursing Program cost	0	17,062,041	0.000000	3,868,666	0	91.00
92.00	Allied health cost	0	17,062,041	0.000000	3,868,666	0	92.00
93.00	All other Medical Education	0	17,062,041	0.000000	3,868,666	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/26/2022 9:38 am
		Title XIX	Subprovider - IPF	Cost
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)			4,801 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,801 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)			4,801 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)			410 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)			942 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)			5,750,209 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			5,750,209 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)			5,750,209 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)			1,197.71 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			491,061 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)			491,061 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-S042		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/26/2022 9:38 am	
		Title XIX		Subprovider - IPF		Cost	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				34,929		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				525,990		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-S042		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/26/2022 9:38 am	
		Title XIX		Subprovider - IPF		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	618,440	5,750,209	0.107551	0	0	90.00
91.00	Nursing Program cost	0	5,750,209	0.000000	0	0	91.00
92.00	Allied health cost	0	5,750,209	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,750,209	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/26/2022 9:38 am
		Title XIX	Subprovider - IRF	Cost
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)			7,092 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			7,092 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)			7,092 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)			53 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)			942 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)			5,660,795 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			5,660,795 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)			5,660,795 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)			798.19 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			42,304 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)			42,304 41.00



COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-T042		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/26/2022 9:38 am	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	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	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				19,163		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				61,467		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)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
<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: 15-0042 Component CCN: 15-T042		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/26/2022 9:38 am	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	724,646	5,660,795	0.128011	0	0	90.00
91.00	Nursing Program cost	0	5,660,795	0.000000	0	0	91.00
92.00	Allied health cost	0	5,660,795	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,660,795	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/26/2022 9:38 am	
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		8,703,642	30.00
31.00	03100	INTENSIVE CARE UNIT		6,543,585	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.189310	6,778,401	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
51.01	05101	ENDOSCOPY	0.237396	442,882	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.315682	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107790	7,732,147	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.224042	298,789	55.00
60.00	06000	LABORATORY	0.139465	9,911,276	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.315418	2,947,393	65.00
66.00	06600	PHYSICAL THERAPY	0.268698	3,082,001	66.00
69.00	06900	ELECTROCARDIOLOGY	0.152424	6,647,669	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.317873	30,032	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.231047	1,040,758	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.400919	1,845,947	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302923	7,568,532	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.189272	5,168	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.720099	455,722	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	3.217975	0	90.00
90.01	04950	WOUND CLINIC	0.405381	9,903	90.01
91.00	09100	EMERGENCY	0.207420	4,196,372	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.251625	2,765,740	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.565454	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		55,758,732	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		55,758,732	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/26/2022 9:38 am
		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
40.00	04000 SUBPROVIDER - IPF		1,597,235	40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.189310	22,151	4,193 50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0 51.00
51.01	05101 ENDOSCOPY	0.237396	0	0 51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.315682	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.107790	55,591	5,992 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.224042	0	0 55.00
60.00	06000 LABORATORY	0.139465	199,468	27,819 60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0 63.00
65.00	06500 RESPIRATORY THERAPY	0.315418	134,188	42,325 65.00
66.00	06600 PHYSICAL THERAPY	0.268698	29,710	7,983 66.00
69.00	06900 ELECTROCARDIOLOGY	0.152424	17,589	2,681 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
70.01	07001 NEURODIAGNOSTICS	0.317873	11,672	3,710 70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.231047	2,436	2,999 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.400919	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.302923	188,739	57,173 73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.189272	0	0 75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0.000000	0	0 76.00
76.01	03951 INPATIENT DIALYSIS	0.720099	0	0 76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	3.217975	0	0 90.00
90.01	04950 WOUND CLINIC	0.405381	0	0 90.01
91.00	09100 EMERGENCY	0.207420	253,344	52,549 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.251625	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.565454	0	0 96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		914,888	207,424 200.00
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)		914,888	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/26/2022 9:38 am		
		Title XVIII	Subprovider - IRF	PPS		
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)		
		1.00	2.00	3.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS			30.00	
31.00	03100	INTENSIVE CARE UNIT			31.00	
40.00	04000	SUBPROVIDER - IPF			40.00	
41.00	04100	SUBPROVIDER - IRF			41.00	
43.00	04300	NURSERY	5,833,111		43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0.189310	125,469	23,753	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.237396	15,318	3,636	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.315682	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107790	506,805	54,629	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.224042	237	53	55.00
60.00	06000	LABORATORY	0.139465	909,678	126,868	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.315418	523,334	165,069	65.00
66.00	06600	PHYSICAL THERAPY	0.268698	7,362,828	1,978,377	66.00
69.00	06900	ELECTROCARDIOLOGY	0.152424	117,991	17,985	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.317873	11,322	3,599	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.231047	105,830	130,282	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.400919	19,163	7,683	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302923	1,170,936	354,703	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.189272	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.720099	164,508	118,462	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	3.217975	0	0	90.00
90.01	04950	WOUND CLINIC	0.405381	0	0	90.01
91.00	09100	EMERGENCY	0.207420	246,894	51,211	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.251625	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.565454	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,280,313	3,036,310	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)		11,280,313		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/26/2022 9:38 am	
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		331,734	30.00
31.00	03100	INTENSIVE CARE UNIT		256,191	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		106,593	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.189310	241,890	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
51.01	05101	ENDOSCOPY	0.237396	16,082	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.315682	395,922	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107790	273,908	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.223497	2,156	55.00
60.00	06000	LABORATORY	0.139465	485,761	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.315418	179,251	65.00
66.00	06600	PHYSICAL THERAPY	0.268698	108,953	66.00
69.00	06900	ELECTROCARDIOLOGY	0.152424	164,078	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.317037	4,211	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.231047	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.400919	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302923	396,593	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.189029	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.720099	7,341	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	3.217975	0	90.00
90.01	04950	WOUND CLINIC	0.405381	293	90.01
91.00	09100	EMERGENCY	0.207420	283,964	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.251625	1,805	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.565454	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,562,208	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		2,562,208	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/26/2022 9:38 am
		Title XIX	Subprovider - IPF	Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF		678,853	40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.189310	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	51.00
51.01	05101 ENDOSCOPY	0.237396	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.315682	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.107790	19,923	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.223497	0	55.00
60.00	06000 LABORATORY	0.139465	44,861	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.315418	12,552	65.00
66.00	06600 PHYSICAL THERAPY	0.268698	10,987	66.00
69.00	06900 ELECTROCARDIOLOGY	0.152424	3,313	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001 NEURODIAGNOSTICS	0.317037	970	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.231047	2,299	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.400919	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.302923	50,602	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.189029	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0.000000	0	76.00
76.01	03951 INPATIENT DIALYSIS	0.720099	890	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	3.217975	0	90.00
90.01	04950 WOUND CLINIC	0.405381	0	90.01
91.00	09100 EMERGENCY	0.207420	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.251625	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.565454	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		146,397	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net charges (line 200 minus line 201)		146,397	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/26/2022 9:38 am
		Title XIX	Subprovider - IRF	Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY		56,391	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.189310	175	33 50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0 51.00
51.01	05101 ENDOSCOPY	0.237396	452	107 51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.315682	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.107790	4,408	475 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.223497	0	0 55.00
60.00	06000 LABORATORY	0.139465	6,506	907 60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0 63.00
65.00	06500 RESPIRATORY THERAPY	0.315418	2,000	631 65.00
66.00	06600 PHYSICAL THERAPY	0.268698	46,295	12,439 66.00
69.00	06900 ELECTROCARDIOLOGY	0.152424	840	128 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
70.01	07001 NEURODIAGNOSTICS	0.317037	106	34 70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.231047	1,676	2,063 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.400919	65	26 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.302923	6,696	2,028 73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.189029	0	0 75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0.000000	0	0 76.00
76.01	03951 INPATIENT DIALYSIS	0.720099	0	0 76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	3.217975	0	0 90.00
90.01	04950 WOUND CLINIC	0.405381	721	292 90.01
91.00	09100 EMERGENCY	0.207420	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.251625	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.565454	0	0 96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		69,940	19,163 200.00
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)		69,940	202.00



CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/26/2022 9:38 am
		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)		11,491,181	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,940,969	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)		170,448	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		6,623	2.04
3.00	Managed Care Simulated Payments		4,520,925	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		88.97	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).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		20.77	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		20.77	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.233449	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.228257	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.228257	21.00
22.00	IME payment adjustment (see instructions)		1,808,987	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		529,952	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)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		1,808,987	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		529,952	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)		18.48	31.00
32.00	Sum of lines 30 and 31		23.48	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.59	33.00
34.00	Disproportionate share adjustment (see instructions)		331,405	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/26/2022 9:38 am
		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)	0.000282312	0.000242542	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,340,371	1,744,364	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,750,469	439,676	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,190,145		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)	19,939,758		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	19,583,844		48.00
		<b>Amount</b>		
		1.00		
49.00	Total payment for inpatient operating costs (see instructions)		20,469,710	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,352,730	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).		868,073	52.00
53.00	Nursing and Allied Health Managed Care payment		24,316	53.00
54.00	Special add-on payments for new technologies		99,144	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)		43,253	58.00
59.00	Total (sum of amounts on lines 49 through 58)		22,857,226	59.00
60.00	Primary payer payments		17,514	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		22,839,712	61.00
62.00	Deductibles billed to program beneficiaries		1,900,588	62.00
63.00	Coinurance billed to program beneficiaries		24,857	63.00
64.00	Allowable bad debts (see instructions)		252,869	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		164,365	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		21,078,632	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)		-105,104	70.93
70.94	HRR adjustment amount (see instructions)		-112,186	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/26/2022 9:38 am	
		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)			217,043	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			20,644,299	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			18,854,751	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)			1,789,548	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			360,139	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>					
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	
<b>HSP Bonus Payment Amount</b>					
100.00	HSP bonus amount (see instructions)			0	100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>					
101.00	HVBP adjustment factor (see instructions)		0.9909061528	0.9909100000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
<b>HRR Adjustment for HSP Bonus Payment</b>					
103.00	HRR adjustment factor (see instructions)		0.9927	0.9930	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
<b>Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment</b>					
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
<b>Cost Reimbursement</b>					
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
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>					
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
<b>Adjustment to Medicare Part A Inpatient Reimbursement</b>					
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
<b>Comparison of PPS versus Cost Reimbursement</b>					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0042

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/26/2022 9:38 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	11,491,181	0	11,491,181		11,491,181	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,940,969	0		3,940,969	3,940,969	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	170,448	0	170,448		170,448	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	6,623	0		6,623	6,623	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	4,520,925	0	3,443,531	1,077,394	4,520,925	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.228257	0.228257	0.228257	0.228257		5.00
6.00	IME payment adjustment (see instructions)	22.00	1,808,987	0	1,347,019	461,968	1,808,987	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	529,952	0	403,658	126,294	529,952	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	1,808,987	0	1,347,019	461,968	1,808,987	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	529,952	0	403,658	126,294	529,952	9.01
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0859	0.0859	0.0859	0.0859		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	331,405	0	246,773	84,632	331,405	11.00
11.01	Uncompensated care payments	36.00	2,190,145	0	1,750,469	439,676	2,190,145	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	19,939,758	0	15,005,890	4,933,868	19,939,758	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	20,469,710	0	15,409,548	5,060,162	20,469,710	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,352,730	0	1,018,678	334,052	1,352,730	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0042

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/26/2022 9:38 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	99,144	0	66,509	32,635	99,144	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	16,494,735	5,426,849	21,921,584	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,161,740	0	869,648	292,092	1,161,740	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	32,645	0	30,497	2,148	32,645	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.1363	0.1363	0.1363	0.1363		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	158,345	0	118,533	39,812	158,345	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,352,730	0	1,018,678	334,052	1,352,730	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0042

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

Worksheet E  
Part A Exhibit 5  
Date/Time Prepared:  
5/26/2022 9:38 am

		Title XVIII			Hospital	PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00				1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	11,491,181	11,491,181		11,491,181	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,940,969		3,940,969	3,940,969	
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	170,448	170,448		170,448	
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	6,623		6,623	6,623	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	
4.00	Managed care simulated payments	3.00	4,520,925	3,443,531	1,077,394	4,520,925	
<b>Indirect Medical Education Adjustment</b>							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.228257	0.228257	0.228257		
6.00	IME payment adjustment (see instructions)	22.00	1,808,987	1,347,019	461,968	1,808,987	
6.01	IME payment adjustment for managed care (see instructions)	22.01	529,952	403,658	126,294	529,952	
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	1,808,987	1,347,019	461,968	1,808,987	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	529,952	403,658	126,294	529,952	
<b>Disproportionate Share Adjustment</b>							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0859	0.0859	0.0859		
11.00	Disproportionate share adjustment (see instructions)	34.00	331,405	246,773	84,632	331,405	
11.01	Uncompensated care payments	36.00	2,190,145	1,750,469	439,676	2,190,145	
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	
13.00	Subtotal (see instructions)	47.00	19,939,758	15,005,890	4,933,868	19,939,758	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	20,469,710	15,409,548	5,060,162	20,469,710	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,352,730	1,018,678	334,052	1,352,730	
17.00	Special add-on payments for new technologies	54.00	99,144	66,509	32,635	99,144	
17.01	Net organ acquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	
19.00	SUBTOTAL			16,494,735	5,426,849	21,921,584	

		Title XVIII			Hospital	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,161,740	869,648	292,092	1,161,740	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	32,645	30,497	2,148	32,645	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.1363	0.1363	0.1363		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	158,345	118,533	39,812	158,345	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,352,730	1,018,678	334,052	1,352,730	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-105,104	-105,104	0	-105,104	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-112,186	-84,371	-27,815	-112,186	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		163,053	53,990	217,043	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 9:38 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		8,442	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		27,574,249	2.00
3.00	OPPS payments		24,803,122	3.00
4.00	Outlier payment (see instructions)		14,557	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		29,267	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		8,442	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		27,869	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)		27,869	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)		27,869	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		19,427	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)		8,442	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)		24,846,946	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)		4,639,810	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)		20,215,578	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		752,545	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)		20,968,123	30.00
31.00	Primary payer payments		4,165	31.00
32.00	Subtotal (line 30 minus line 31)		20,963,958	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)		405,128	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		263,333	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		21,227,291	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)		0	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)		21,227,291	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		0	40.03
41.00	Interim payments		21,041,887	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		185,404	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	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



CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 9:38 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		131	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,044	2.00
3.00	OPPS payments		1,296	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)		131	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		434	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)		434	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)		434	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		303	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)		131	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)		1,296	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)		86	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,341	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,341	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,341	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)		1,341	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 before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,341	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		0	40.03
41.00	Interim payments		1,332	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		9	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 9:38 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			167 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			1,172 2.00
3.00	OPPS payments			929 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			4 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			167 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			550 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)			550 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)			550 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			383 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)			167 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)			933 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)			135 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)			965 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)			965 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			965 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)			965 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)			965 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			0 40.03
41.00	Interim payments			947 41.00
41.01	Interim payments-PARHM			0 41.01
42.00	Tentative settlement (for contractors use only)			0 42.00
42.01	Tentative settlement-PARHM (for contractor use only)			0 42.01
43.00	Balance due provider/program (see instructions)			18 43.00
43.01	Balance due provider/program-PARHM (see instructions)			0 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: 15-0042

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/26/2022 9:38 am

		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		18,094,020		20,175,503	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	12/31/2021	370,731	12/31/2021	660,684	3.01	
3.02		12/01/2021	390,000	12/01/2021	205,700	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)		760,731		866,384	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)		18,854,751		21,041,887	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		1,789,548		185,404	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		20,644,299		21,227,291	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: 15-0042  
Component CCN: 15-S042

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/26/2022 9:38 am

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		767,783		1,332	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)		767,783		1,332	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		110,818		9	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		878,601		1,341	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: 15-0042  
Component CCN: 15-T042

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/26/2022 9:38 am

Title XVIII

Subprovider -  
IRF

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					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		8,523,673		947	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)		8,523,673		947	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		75,798		18	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		8,599,471		965	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/26/2022 9:38 am
		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: 15-0042 Component CCN: 15-S042	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part II Date/Time Prepared: 5/26/2022 9:38 am
		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)			846,795 1.00
2.00	Net IPF PPS Outlier Payments			1,560 2.00
3.00	Net IPF PPS ECT Payments			3,982 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)			3.95 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			3.95 8.00
9.00	Average Daily Census (see instructions)			13.153425 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$ .			0.144808 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			122,623 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			974,960 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)			974,960 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			974,960 18.00
19.00	Deductibles			118,644 19.00
20.00	Subtotal (line 18 minus line 19)			856,316 20.00
21.00	Coinsurance			742 21.00
22.00	Subtotal (line 20 minus line 21)			855,574 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			34,088 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			22,157 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			877,731 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			870 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)			878,601 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			767,783 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)			110,818 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			1,560 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)			0.144808 99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part III Date/Time Prepared: 5/26/2022 9:38 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)			8,410,519 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0412 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			222,879 3.00
4.00	Outlier Payments			57,139 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			19.430137 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			8,690,537 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			8,690,537 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			8,690,537 19.00
20.00	Deductibles			63,736 20.00
21.00	Subtotal (line 19 minus line 20)			8,626,801 21.00
22.00	Coinsurance			38,565 22.00
23.00	Subtotal (line 21 minus line 22)			8,588,236 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			11,177 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			7,265 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			8,595,501 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			3,970 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.98	Recovery of accelerated depreciation.			0 31.98
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			8,599,471 32.00
32.01	Sequestration adjustment (see instructions)			0 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			8,523,673 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			75,798 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			57,139 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



CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2022 9:38 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		1,127,605		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,127,605	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1,127,605	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		694,518		8.00
9.00	Ancillary service charges		2,562,208	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		3,256,726	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		3,256,726	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		2,129,121	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		1,127,605	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		1,127,605	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1,127,605	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		1,127,605	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		1,127,605	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		1,127,605	0	40.00
41.00	Interim payments		1,518,798	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-391,193	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2022 9:38 am
		Title XIX	Subprovider - IPF	Cost
		Inpatient 1.00	Outpatient 2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services	525,990		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	525,990	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	525,990	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges	678,853		8.00
9.00	Ancillary service charges	146,397	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	825,250	0	12.00
<b>CUSTOMARY CHARGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	825,250	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	299,260	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	525,990	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	525,990	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	525,990	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	525,990	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	525,990	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	525,990	0	40.00
41.00	Interim payments	349,128	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	176,862	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2022 9:38 am	
		Title XIX	Subprovider - IRF	Cost	
		Inpatient 1.00	Outpatient 2.00		
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services	61,467			1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	61,467		0	4.00
5.00	Inpatient primary payer payments	0			5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	61,467		0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges	56,391			8.00
9.00	Ancillary service charges	69,940		0	9.00
10.00	Organ acquisition charges, net of revenue	0			10.00
11.00	Incentive from target amount computation	0			11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	126,331		0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000		0.000000	15.00
16.00	Total customary charges (see instructions)	126,331		0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	64,864		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0		0	18.00
19.00	Interns and Residents (see instructions)	0		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	61,467		0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments	0		0	22.00
23.00	Outlier payments	0		0	23.00
24.00	Program capital payments	0		0	24.00
25.00	Capital exception payments (see instructions)	0		0	25.00
26.00	Routine and Ancillary service other pass through costs	0		0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	61,467		0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)	0		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	61,467		0	31.00
32.00	Deductibles	0		0	32.00
33.00	Coinurance	0		0	33.00
34.00	Allowable bad debts (see instructions)	0		0	34.00
35.00	Utilization review	0		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	61,467		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0	37.00
38.00	Subtotal (line 36 ± line 37)	61,467		0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	61,467		0	40.00
41.00	Interim payments	67,086		0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-5,619		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0		0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 5/26/2022 9:38 am
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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	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00

		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	16.18	8.53		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	16.18	8.53		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	16.18	8.53		17.00
18.00	Per resident amount	112,603.66	112,603.66		18.00
19.00	Approved amount for resident costs	1,821,927	960,509	2,782,436	19.00

					1.00
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			2,782,436	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)	13,757	3,041		26.00
27.00	Total Inpatient Days (see instructions)	28,628	28,628		27.00
28.00	Ratio of inpatient days to total inpatient days	0.480544	0.106225		28.00
29.00	Program direct GME amount	1,337,083	295,564	1,632,647	29.00
29.01	Percent reduction for MA DGME		4.07		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		12,029	12,029	30.00
31.00	Net Program direct GME amount			1,620,618	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 5/26/2022 9:38 am
		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)		0	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)		31,866,462	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)		17,514	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		31,848,948	41.00
<b>Part B Reasonable Cost</b>				
42.00	Reasonable cost (see instructions)		27,614,476	42.00
43.00	Primary payer payments (see instructions)		4,165	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		27,610,311	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		59,459,259	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.535643	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.464357	47.00
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48.00	Total program GME payment (line 31)		1,620,618	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		868,073	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		752,545	50.00

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

Provider CCN: 15-0042

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

Worksheet G

Date/Time Prepared:  
5/26/2022 9:38 am

		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	34,182,458	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	73,699,005	0	0	0	4.00
5.00	Other receivable	12,139,434	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-45,492,511	0	0	0	6.00
7.00	Inventory	3,133,114	0	0	0	7.00
8.00	Prepaid expenses	6,884,472	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	84,545,972	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	6,581,448	0	0	0	12.00
13.00	Land improvements	10,726,598	0	0	0	13.00
14.00	Accumulated depreciation	-7,274,356	0	0	0	14.00
15.00	Buildings	171,730,091	0	0	0	15.00
16.00	Accumulated depreciation	-83,964,363	0	0	0	16.00
17.00	Leasehold improvements	515,426	0	0	0	17.00
18.00	Accumulated depreciation	-393,545	0	0	0	18.00
19.00	Fixed equipment	110,533,749	0	0	0	19.00
20.00	Accumulated depreciation	-66,476,676	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	114,069,574	0	0	0	23.00
24.00	Accumulated depreciation	-95,797,751	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	160,250,195	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	103,733,756	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	4,372,680	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	108,106,436	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	352,902,603	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	2,856,870	0	0	0	37.00
38.00	Salaries, wages, and fees payable	16,277,897	0	0	0	38.00
39.00	Payroll taxes payable	1,261,364	0	0	0	39.00
40.00	Notes and loans payable (short term)	31,761,776	0	0	0	40.00
41.00	Deferred income	1,206,847	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	34,157	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	53,398,911	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	106,013,119	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	106,013,119	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	159,412,030	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	193,490,573	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)	193,490,573	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	352,902,603	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0042

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

Worksheet G-1

Date/Time Prepared:  
5/26/2022 9:38 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		186,031,187		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		7,459,386			2.00
3.00	Total (sum of line 1 and line 2)		193,490,573		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)		193,490,573		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)		193,490,573		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: 15-0042

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/26/2022 9:38 am

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	23,239,756		23,239,756	1.00
2.00	SUBPROVIDER - IPF	9,003,731		9,003,731	2.00
3.00	SUBPROVIDER - IRF	8,072,321		8,072,321	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)	40,315,808		40,315,808	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	15,051,098		15,051,098	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	15,051,098		15,051,098	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	55,366,906		55,366,906	17.00
18.00	Ancillary services	130,086,047	402,434,994	532,521,041	18.00
19.00	Outpatient services	10,819,597	49,017,388	59,836,985	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		0	0	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	0	2,023,096	2,023,096	26.00
27.00	DME	0	407,736	407,736	27.00
27.01	PHYSICIAN OFFICE	0	759,600	759,600	27.01
27.02	PROFESSIONAL FEES	2,971,465	6,140,792	9,112,257	27.02
27.03	DIETARY REVENUE	0	592,822	592,822	27.03
27.04	GSPN IM RESDNT FACULTY PRACTIC	0	0	0	27.04
27.05	ADMIN	0	0	0	27.05
27.06	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	27.06
27.07	PRO FEES	0	0	0	27.07
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	199,244,015	461,376,428	660,620,443	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		254,017,975		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)		254,017,975		43.00



STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0042

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

Worksheet G-3

Date/Time Prepared:  
5/26/2022 9:38 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	660,620,443	1.00
2.00	Less contractual allowances and discounts on patients' accounts	427,721,142	2.00
3.00	Net patient revenues (line 1 minus line 2)	232,899,301	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	254,017,975	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-21,118,674	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	6,211,140	23.00
24.00	OTHER OPERATING INCOME	6,169,579	24.00
24.01	INTEREST INCOME AND DISTRIBUTIONS	5,370,168	24.01
24.02	OTHER INCOME	2,635,176	24.02
24.03	OTHER NONOPERATING INCOME	2,132,422	24.03
24.04	UNREALIZED GAIN/LOSS ON INVESTMENTS	2,549,672	24.04
24.05	OTHER INCOME AND EXPENSE	0	24.05
24.06	OTHER INCOME AND EXPENSE	0	24.06
24.50	COVID-19 PHE Funding	3,509,903	24.50
25.00	Total other income (sum of lines 6-24)	28,578,060	25.00
26.00	Total (line 5 plus line 25)	7,459,386	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)	7,459,386	29.00

ANALYSIS OF HOSPITAL-BASED HOSPI CE COSTS

Provider CCN: 15-0042

Period: From 01/01/2021

Worksheet 0

Hospice CCN: 15-1526

To 12/31/2021

Date/Time Prepared: 5/26/2022 9:38 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI - CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	61,856	255,807	317,663	-114,362	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	3,224	3,224	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	2,590	2,590	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	13.00
14.00	PHARMACY*	0	27	27	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
<b>DIRECT PATIENT CARE SERVICE COST CENTERS</b>						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	25.00
26.00	PHYSICIAN SERVICES**	18,086	24,777	42,863	0	26.00
27.00	NURSE PRACTITIONER**	11,419	0	11,419	0	27.00
28.00	REGISTERED NURSE**	196,929	0	196,929	0	28.00
29.00	LPN/LVN**	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	88,323	0	88,323	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	41,440	0	41,440	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	30,647	0	30,647	0	46.00
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	71.00
100.00	TOTAL	448,700	286,425	735,125	-114,362	620,763

\* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0042

Period: From 01/01/2021

Worksheet 0

Hospice CCN: 15-1526

To 12/31/2021

Date/Time Prepared: 5/26/2022 9:38 am

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	203,301	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	3,224	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	2,590	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	27	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	17.00
<b>DIRECT PATIENT CARE SERVICE COST CENTERS</b>				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	42,863	26.00
27.00	NURSE PRACTITIONER**	0	11,419	27.00
28.00	REGISTERED NURSE**	0	196,929	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	88,323	33.00
34.00	SPIRITUAL COUNSELING**	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	41,440	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	30,647	46.00
<b>NONREIMBURSABLE COST CENTERS</b>				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	620,763	100.00

\* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPI CE COSTS FOR HOSPI CE ROUTINE HOME CARE	Provi der CCN: 15-0042 Hospi ce CCN: 15-1526	Peri od: From 01/01/2021 To 12/31/2021	Worksheet 0-2 Date/Time Prepared: 5/26/2022 9:38 am
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		SALARIES	OTHER	SUBTOTAL (col . 1 + col . 2)	Hospi ce I RECLASSIFI - CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	16,435	0	16,435	0	16,435	26.00
27.00	NURSE PRACTITIONER	10,376	0	10,376	0	10,376	27.00
28.00	REGISTERED NURSE	178,946	0	178,946	0	178,946	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	80,258	0	80,258	0	80,258	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPI CE AIDE & HOME MAKER SERVICES	37,656	0	37,656	0	37,656	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	27,849	0	27,849	0	27,849	46.00
100.00	TOTAL *	351,520	0	351,520	0	351,520	100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col . 5 ± col . 6)	
		6.00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	16,435	26.00
27.00	NURSE PRACTITIONER	0	10,376	27.00
28.00	REGISTERED NURSE	0	178,946	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	80,258	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPI CE AIDE & HOME MAKER SERVICES	0	37,656	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	27,849	46.00
100.00	TOTAL *	0	351,520	100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPIRE CARE

Provider CCN: 15-0042

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

Worksheet 0-3

Hospice CCN: 15-1526

Date/Time Prepared: 5/26/2022 9:38 am

		Hospice I			
		SALARIES	OTHER	RECLASSIFI - CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00
		SUBTOTAL (col. 1 + col. 2)		SUBTOTAL	
DIRECT PATIENT CARE SERVICE COST CENTERS					
25.00	INPATIENT CARE-CONTRACTED		0	0	0 25.00
26.00	PHYSICIAN SERVICES	53	0	53	53 26.00
27.00	NURSE PRACTITIONER	34	0	34	34 27.00
28.00	REGISTERED NURSE	580	0	580	580 28.00
29.00	LPN/LVN	0	0	0	0 29.00
30.00	PHYSICAL THERAPY	0	0	0	0 30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0 31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0 32.00
33.00	MEDICAL SOCIAL SERVICES	260	0	260	260 33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0 34.00
35.00	DIETARY COUNSELING	0	0	0	0 35.00
36.00	COUNSELING - OTHER	0	0	0	0 36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	122	0	122	122 37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0 38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0 39.00
40.00	IMAGING SERVICES	0	0	0	0 40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0 41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0 42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0 42.50
43.00	OUTPATIENT SERVICES	0	0	0	0 43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0 44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0 45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	90	0	90	90 46.00
100.00	TOTAL *	1,139	0	1,139	1,139 100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)
		6.00	7.00
DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0 25.00
26.00	PHYSICIAN SERVICES	0	53 26.00
27.00	NURSE PRACTITIONER	0	34 27.00
28.00	REGISTERED NURSE	0	580 28.00
29.00	LPN/LVN	0	0 29.00
30.00	PHYSICAL THERAPY	0	0 30.00
31.00	OCCUPATIONAL THERAPY	0	0 31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0 32.00
33.00	MEDICAL SOCIAL SERVICES	0	260 33.00
34.00	SPIRITUAL COUNSELING	0	0 34.00
35.00	DIETARY COUNSELING	0	0 35.00
36.00	COUNSELING - OTHER	0	0 36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	122 37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0 38.00
39.00	PATIENT TRANSPORTATION	0	0 39.00
40.00	IMAGING SERVICES	0	0 40.00
41.00	LABS & DIAGNOSTICS	0	0 41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0 42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0 42.50
43.00	OUTPATIENT SERVICES	0	0 43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0 44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0 45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	90 46.00
100.00	TOTAL *	0	1,139 100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE	Provider CCN: 15-0042 Hospice CCN: 15-1526	Period: From 01/01/2021 To 12/31/2021	Worksheet 0-4 Date/Time Prepared: 5/26/2022 9:38 am
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		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	Hospice I RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	1,598	24,777	26,375	0	26,375	26.00
27.00	NURSE PRACTITIONER	1,009	0	1,009	0	1,009	27.00
28.00	REGISTERED NURSE	17,403	0	17,403	0	17,403	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	7,805	0	7,805	0	7,805	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	3,662	0	3,662	0	3,662	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	2,708	0	2,708	0	2,708	46.00
100.00	TOTAL *	34,185	24,777	58,962	0	58,962	100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	26,375	26.00
27.00	NURSE PRACTITIONER	0	1,009	27.00
28.00	REGISTERED NURSE	0	17,403	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	7,805	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	3,662	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	2,708	46.00
100.00	TOTAL *	0	58,962	100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 15-0042

Period: From 01/01/2021

Worksheet 0-5

Hospice CCN: 15-1526

To 12/31/2021

Date/Time Prepared: 5/26/2022 9:38 am

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	0	115,196	115,196	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	523	523	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	155,644	155,644	3.00
4.00	ADMINISTRATIVE & GENERAL	203,301	91,546	294,847	4.00
5.00	PLANT OPERATION & MAINTENANCE	3,224	117,980	121,204	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	49,060	49,060	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	97,472	97,472	9.00
10.00	ROUTINE MEDICAL SUPPLIES	2,590	739	3,329	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	27	7	34	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
<b>LEVEL OF CARE</b>					
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	351,520		351,520	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	1,139		1,139	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	58,962		58,962	53.00
<b>NONREIMBURSABLE COST CENTERS</b>					
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	620,763	628,167	1,248,930	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period: From 01/01/2021

Worksheet 0-6

Hospice CCN: 15-1526

To 12/31/2021

Part I  
Date/Time Prepared:  
5/26/2022 9:38 am

Descriptions	Hospice I				SUBTOTAL	
	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT		
	0	1.00	2.00	3.00	3A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIX	115,196	115,196			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	523		523		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	155,644	0	0	155,644	3.00
4.00	ADMINISTRATIVE & GENERAL	294,847	0	0	0	294,847
5.00	PLANT OPERATION & MAINTENANCE	121,204	0	0	0	121,204
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0
7.00	HOUSEKEEPING	49,060	0	0	0	49,060
8.00	DIETARY	0	0	0	0	0
9.00	NURSING ADMINISTRATION	97,472	0	0	0	97,472
10.00	ROUTINE MEDICAL SUPPLIES	3,329	0	0	0	3,329
11.00	MEDICAL RECORDS	0	0	0	0	0
12.00	STAFF TRANSPORTATION	0	0	0	0	0
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0
14.00	PHARMACY	34	0	0	0	34
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0
16.00	OTHER GENERAL SERVICE	0	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0
<b>LEVEL OF CARE</b>						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0
51.00	HOSPICE ROUTINE HOME CARE	351,520			144,777	496,297
52.00	HOSPICE INPATIENT RESPIRE CARE	1,139	2,078	9	196	3,422
53.00	HOSPICE GENERAL INPATIENT CARE	58,962	113,118	514	10,671	183,265
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0
61.00	VOLUNTEER PROGRAM	0	0	0	0	0
62.00	FUNDRAISING	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0
66.00	RESIDENTIAL CARE	0	0	0	0	0
67.00	ADVERTISING	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0
69.00	THRIFT STORE	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0
99.00	NEGATIVE COST CENTER	0	0	0	0	0
100.00	TOTAL	1,248,930	115,196	523	155,644	1,248,930



COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period: From 01/01/2021

Worksheet 0-6

Hospice CCN: 15-1526

To 12/31/2021

Part I  
Date/Time Prepared:  
5/26/2022 9:38 am

Descriptions	Hospice I					
	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	4.00	5.00	6.00	7.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00 ADMINISTRATIVE & GENERAL	294,847					4.00
5.00 PLANT OPERATION & MAINTENANCE	37,457	158,661				5.00
6.00 LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00 HOUSEKEEPING	15,161	0		64,221		7.00
8.00 DIETARY	0	0		0	0	8.00
9.00 NURSING ADMINISTRATION	30,122	0		0		9.00
10.00 ROUTINE MEDICAL SUPPLIES	1,029	0		0		10.00
11.00 MEDICAL RECORDS	0	0		0		11.00
12.00 STAFF TRANSPORTATION	0	0		0		12.00
13.00 VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00 PHARMACY	11	0		0		14.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00 OTHER GENERAL SERVICE	0	0		0		16.00
17.00 PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
<b>LEVEL OF CARE</b>						
50.00 HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00 HOSPICE ROUTINE HOME CARE	153,373					51.00
52.00 HOSPICE INPATIENT RESPIRE CARE	1,058	2,862	0	1,159	0	52.00
53.00 HOSPICE GENERAL INPATIENT CARE	56,636	155,799	0	63,062	0	53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00 BEREAVEMENT PROGRAM	0	0		0		60.00
61.00 VOLUNTEER PROGRAM	0	0		0		61.00
62.00 FUNDRAISING	0	0		0		62.00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00 PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00 OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00 RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00 ADVERTISING	0	0		0		67.00
68.00 TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00 THIRFT STORE	0	0		0		69.00
70.00 NURSING FACILITY ROOM & BOARD						70.00
71.00 OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00 NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00 TOTAL	294,847	158,661	0	64,221	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:

Worksheet 0-6

Hospice CCN: 15-1526

From 01/01/2021  
To 12/31/2021

Part I  
Date/Time Prepared:  
5/26/2022 9:38 am

Descriptions	Hospice I					
	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
	9.00	10.00	11.00	12.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00	127,594					9.00
10.00	0	4,358				10.00
11.00	0		0			11.00
12.00	0			0		12.00
13.00	0			0	0	13.00
14.00	0			0	0	14.00
15.00	0			0	0	15.00
16.00	0			0	0	16.00
17.00	0			0	0	17.00
<b>LEVEL OF CARE</b>						
50.00	0	0	0	0	0	50.00
51.00	118,683	3,960	0	0	0	51.00
52.00	164	13	0	0	0	52.00
53.00	8,747	385	0	0	0	53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	0			0	0	60.00
61.00	0			0	0	61.00
62.00	0			0	0	62.00
63.00	0			0	0	63.00
64.00	0			0	0	64.00
65.00	0			0	0	65.00
66.00	0			0	0	66.00
67.00	0			0	0	67.00
68.00	0			0	0	68.00
69.00	0			0	0	69.00
70.00						70.00
71.00	0			0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	127,594	4,358	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period: From 01/01/2021

Worksheet 0-6

Hospice CCN: 15-1526

To 12/31/2021

Part I  
Date/Time Prepared:  
5/26/2022 9:38 am

Descriptions	Hospice I				TOTAL	
	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
	14.00	15.00	16.00	17.00	18.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00	45					14.00
15.00	0	0				15.00
16.00	0		0			16.00
17.00				0		17.00
<b>LEVEL OF CARE</b>						
50.00	0	0	0		0	50.00
51.00	41	0	0		772,354	51.00
52.00	0	0	0	0	8,678	52.00
53.00	4	0	0	0	467,898	53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	0		0		0	60.00
61.00	0		0		0	61.00
62.00	0		0		0	62.00
63.00	0		0		0	63.00
64.00	0		0		0	64.00
65.00	0		0		0	65.00
66.00	0	0	0	0	0	66.00
67.00	0		0		0	67.00
68.00	0		0		0	68.00
69.00	0		0		0	69.00
70.00					0	70.00
71.00	0	0	0	0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	45	0	0	0	1,248,930	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS  
STATISTICAL BASIS

Provider CCN: 15-0042

Period:

Worksheet 0-6

Hospice CCN: 15-1526

From 01/01/2021  
To 12/31/2021

Part II  
Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	HOSPICE I RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIX	388					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		388				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	438,842			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-294,847	954,083	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	121,204	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	49,060	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	97,472	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	3,329	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	34	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
<b>LEVEL OF CARE</b>							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			408,201	0	496,297	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	7	7	553	0	3,422	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	381	381	30,088	0	183,265	53.00
<b>NONREIMBURSABLE COST CENTERS</b>							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	115,196	523	155,644		294,847	100.00
101.00	UNIT COST MULTIPLIER	296.896907	1.347938	0.354670		0.309037	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS  
STATISTICAL BASIS

Provider CCN: 15-0042

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

Worksheet 0-6  
Part II  
Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	388					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		388			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		14,018	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
<b>LEVEL OF CARE</b>							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					13,039	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	7	0	7	0	18	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	381	0	381	0	961	53.00
<b>NONREIMBURSABLE COST CENTERS</b>							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	158,661	0	64,221	0	127,594	100.00
101.00	UNIT COST MULTIPLIER	408.920103	0.000000	165.518041	0.000000	9.102154	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS  
STATISTICAL BASIS

Provider CCN: 15-0042

Period:

Worksheet 0-6

Hospice CCN: 15-1526

From 01/01/2021  
To 12/31/2021

Part II  
Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	5,092					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	4,087	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
<b>LEVEL OF CARE</b>							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	4,627	0	0	0	3,679	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	15	0	0	0	14	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	450	0	0	0	394	53.00
<b>NONREIMBURSABLE COST CENTERS</b>							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	4,358	0	0	0	45	100.00
101.00	UNIT COST MULTIPLIER	0.855852	0.000000	0.000000	0.000000	0.011011	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS  
STATISTICAL BASIS

Provider CCN: 15-0042  
Hospice CCN: 15-1526

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

Worksheet 0-6  
Part II  
Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
<b>LEVEL OF CARE</b>						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER		0			99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 15-0042  
Hospice CCN: 15-1526

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

Worksheet 0-7  
Date/Time Prepared:  
5/26/2022 9:38 am

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				0	1.00	2.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.268698	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.302923	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.565454	0	0	0	5.00
6.00	LABORATORY	60.00	0.139465	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	1.231047	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.223497	0	0	0	9.00
10.00	MH ANCILLARY OUTPATIENT	76.00	0.000000	0	0	0	10.00
10.01	INPATIENT DIALYSIS	76.01	0.720099	0	0	0	10.01
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)		Shared Service Costs by LOC			
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.00	MH ANCILLARY OUTPATIENT	0	0	0	0	0	10.00
10.01	INPATIENT DIALYSIS	0	0	0	0	0	10.01
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00



CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0042

Period: From 01/01/2021

Worksheet 0-8

Hospice CCN: 15-1526

To 12/31/2021

Date/Time Prepared: 5/26/2022 9:38 am

		Hospice I			
		TITLE XVII MEDI CARE	TITLE XIX MEDI CAID	TOTAL	
		1.00	2.00	3.00	
<b>HOSPICE CONTINUOUS HOME CARE</b>					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)				4.00
5.00	Program cost (line 3 times line 4)	0	0	0	5.00
<b>HOSPICE ROUTINE HOME CARE</b>					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			772,354	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			4,627	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			166.92	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	3,497	89		9.00
10.00	Program cost (line 8 times line 9)	583,719	14,856		10.00
<b>HOSPICE INPATIENT RESPITE CARE</b>					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			8,678	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			15	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			578.53	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	12	0		14.00
15.00	Program cost (line 13 times line 14)	6,942	0		15.00
<b>HOSPICE GENERAL INPATIENT CARE</b>					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			467,898	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			450	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			1,039.77	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	339	37		19.00
20.00	Program cost (line 18 times line 19)	352,482	38,471		20.00
<b>TOTAL HOSPICE CARE</b>					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,248,930	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			5,092	22.00
23.00	Average cost per diem (line 21 divided by line 22)			245.27	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 5/26/2022 9:38 am
		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		1,161,740	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		32,645	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)		45.85	3.00
4.00	Number of interns & residents (see instructions)		20.77	4.00
5.00	Indirect medical education percentage (see instructions)		13.63	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)		158,345	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,352,730	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