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: 15-0010	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/28/2021 9:22 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/28/2021 Time: 9:22 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ASCENSION ST VINCENT KOKOMO (15-0010) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) BECKY JACOBSON
Officer or Administrator of Provider(s)

VP OF FINANCE
Title

11/28/2021 09:22:20 AM
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	173,834	-158,098	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-7,182	16		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	166,652	-158,082	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2021 9:22 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1907 WEST SYCAMORE	PO Box:			1.00
2.00	City: KOKOMO	State: IN	Zip Code: 46901	County: HOWARD	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ASCENSION ST VINCENT KOKOMO	150010	29020	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	ASCENSION ST VINCENT KOKOMO REHAB	15T010	29020	5	07/01/2002	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2020	06/30/2021	20.00
21.00	Type of Control (see instructions)	1		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2021 9:22 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.	324	256	2	7	3,535	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	17	0	0	364		25.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0010	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/28/2021 9:22 am

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.	Y	Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	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	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0010	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/28/2021 9:22 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0010	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/28/2021 9:22 am

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	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	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0010	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/28/2021 9:22 am

				V	XIX	
				1.00	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		108.00

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	875,466	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2021 9:22 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)	Y	15HO46	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: ST VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 250 W 96TH STREET, SUITE 215	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46260	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0010	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/28/2021 9:22 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. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part II | Date/Time Prepared: 11/28/2021 9:22 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/07/2021	Y	10/07/2021	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part II Date/Time Prepared: 11/28/2021 9:22 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					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
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL		HILL		41.00
42.00	Enter the employer/company name of the cost report preparer.	ASCENSION HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3519		JILL.HILL1@ASCENSION.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0010	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/28/2021 9:22 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER NET REVENUE MANAGEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I Date/Time Prepared: 11/28/2021 9:22 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	98	35,770	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)		98	35,770	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	13	4,745	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)		111	40,515	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	18	6,570		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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		129				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)		8	2,920			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: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2021 9:22 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,518	272	13,691			1.00
2.00	HMO and other (see instructions)	3,957	3,544				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	918	364				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)	6,518	272	13,691			7.00
8.00	INTENSIVE CARE UNIT	883	174	2,624			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		134	1,430			13.00
14.00	Total (see instructions)	7,401	580	17,745	0.00	432.52	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	2,368	17	4,185	0.00	18.38	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	450.90	27.00
28.00	Observation Bed Days		0	1,271			28.00
29.00	Ambulance Trips	2,179					29.00
30.00	Employee discount days (see instruction)			260			30.00
31.00	Employee discount days - IRF			21			31.00
32.00	Labor & delivery days (see instructions)	0	0	1,527			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: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2021 9:22 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,390	69	4,669	1.00
2.00	HMO and other (see instructions)			730	1,209		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				28		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	1,390	69	4,669	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	198	49	311	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part II | Date/Time Prepared: 11/28/2021 9:22 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	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	32,449,481	-12,855	32,436,626	989,232.00	32.79	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		107,518	0	107,518	595.00	180.70	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		544,345	0	544,345	3,629.00	150.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,336,955	165,865	3,502,820	116,625.00	30.03	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		428,420	0	428,420	3,977.40	107.71	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		8,825,787	0	8,825,787	173,569.00	50.85	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		13,280,753	0	13,280,753			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		394,739	0	394,739			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		44,004	0	44,004			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		302,497	0	302,497			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		2,387,955	0	2,387,955			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part II Date/Time Prepared: 11/28/2021 9:22 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
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	343,320	1,509	344,829	321.00	1,074.23	26.00
27.00	Administrative & General	5.00	2,390,338	-704,325	1,686,013	36,664.00	45.99	27.00
28.00	Administrative & General under contract (see inst.)		745,935	0	745,935	5,583.00	133.61	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,266,286	0	1,266,286	54,582.00	23.20	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		871,578	0	871,578	35,484.00	24.56	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,500,180	84,374	1,584,554	45,782.00	34.61	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,521,801	23,999	1,545,800	31,998.00	48.31	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part III Date/Time Prepared: 11/28/2021 9:22 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		34,788,935	-12,855	34,776,080	1,081,252.00	32.16	1.00
2.00	Excluded area salaries (see instructions)		3,336,955	165,865	3,502,820	116,625.00	30.03	2.00
3.00	Subtotal salaries (line 1 minus line 2)		31,451,980	-178,720	31,273,260	964,627.00	32.42	3.00
4.00	Subtotal other wages & related costs (see inst.)		9,254,207	0	9,254,207	177,546.40	52.12	4.00
5.00	Subtotal wage-related costs (see inst.)		15,712,712	0	15,712,712	0.00	50.24	5.00
6.00	Total (sum of lines 3 thru 5)		56,418,899	-178,720	56,240,179	1,142,173.40	49.24	6.00
7.00	Total overhead cost (see instructions)		8,639,438	-594,443	8,044,995	210,414.00	38.23	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part IV | Date/Time Prepared: 11/28/2021 9:22 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,655,278	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	253,878	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	7,464,482	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	974,221	9.00
10.00	Dental, Hearing and Vision Plan	133,088	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	44,873	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)	264,653	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	88,065	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,366,240	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	11,309	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	24,666	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	13,280,753	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part V | Date/Time Prepared: 11/28/2021 9:22 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	428,420	13,280,753	1.00
2.00	Hospital	428,420	13,280,753	2.00
3.00	Subprovider - IPF			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			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-10 | Date/Time Prepared: 11/28/2021 9:22 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.206321	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	10,245,373	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	95,180,857	6.00
7.00	Medicaid cost (line 1 times line 6)	19,637,810	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)	9,392,437	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)	9,392,437	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)	8,243,419	893,911	9,137,330	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,700,790	893,911	2,594,701	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)	1,700,790	893,911	2,594,701	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)	6,633,336	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	171,160	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	263,323	27.01
28.00	Non-Medicare bad debt expense (see instructions)	6,370,013	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,406,430	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,001,131	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	13,393,568	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A | Date/Time Prepared: 11/28/2021 9:22 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,712,457	3,712,457	-6,261	3,706,196	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,837,186	3,837,186	0	3,837,186	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	343,320	7,153,749	7,497,069	48,681	7,545,750	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,390,338	40,977,575	43,367,913	-794,629	42,573,284	5.00
7.00	00700	OPERATION OF PLANT	0	4,167,204	4,167,204	17,683	4,184,887	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	460,482	460,482	8.00
9.00	00900	HOUSEKEEPING	0	1,922,182	1,922,182	-396,934	1,525,248	9.00
10.00	01000	DIETARY	0	2,224,338	2,224,338	-1,040,205	1,184,133	10.00
11.00	01100	CAFETERIA	0	0	0	1,065,894	1,065,894	11.00
13.00	01300	NURSING ADMINISTRATION	1,500,180	343,341	1,843,521	85,367	1,928,888	13.00
15.00	01500	PHARMACY	1,521,801	192,146	1,713,947	12,706,604	14,420,551	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	390	390	0	390	16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	78,753	35,164	113,917	95,664	209,581	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,616,107	907,511	6,523,618	167,386	6,691,004	30.00
31.00	03100	INTENSIVE CARE UNIT	1,814,999	301,527	2,116,526	59,692	2,176,218	31.00
41.00	04100	SUBPROVIDER - IRF	1,100,589	138,531	1,239,120	49,581	1,288,701	41.00
43.00	04300	NURSERY	0	0	0	400,367	400,367	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,400,926	2,348,236	4,749,162	40,221	4,789,383	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,726,145	301,240	2,027,385	-329,123	1,698,262	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,458,780	815,076	2,273,856	-81,811	2,192,045	54.00
54.01	03630	ULTRA SOUND	268,495	28,255	296,750	5,979	302,729	54.01
56.00	05600	RADIOISOTOPE	644,042	371,081	1,015,123	9,786	1,024,909	56.00
57.00	05700	CT SCAN	479,253	62,401	541,654	8,115	549,769	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	295,471	35,705	331,176	4,490	335,666	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,063	13,056	18,119	77	18,196	59.00
60.00	06000	LABORATORY	0	6,209,093	6,209,093	0	6,209,093	60.00
65.00	06500	RESPIRATORY THERAPY	1,059,278	176,208	1,235,486	21,605	1,257,091	65.00
66.00	06600	PHYSICAL THERAPY	3,321,322	506,072	3,827,394	-951,276	2,876,118	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	706,986	706,986	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	260,143	260,143	68.00
69.00	06900	ELECTROCARDIOLOGY	281,293	91,220	372,513	4,849	377,362	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	429,746	206,847	636,593	-3,087	633,506	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	197,744	1,309,176	1,506,920	3,752	1,510,672	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,075,897	3,075,897	0	3,075,897	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,090,829	6,090,829	0	6,090,829	73.00
74.00	07400	RENAL DIALYSIS	0	213,599	213,599	0	213,599	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	675,834	85,259	761,093	10,157	771,250	76.00
76.01	03190	CHEMOTHERAPY	669,592	15,879,113	16,548,705	-12,673,169	3,875,536	76.01
76.02	03330	ENDOSCOPY	13,094	34,969	48,063	199	48,262	76.02
76.03	03950	WOUND CARE CENTER	179,765	723,732	903,497	2,732	906,229	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	219,125	51,144	270,269	-4,984	265,285	90.00
91.00	09100	EMERGENCY	1,600,813	556,983	2,157,796	24,367	2,182,163	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,193,129	246,099	1,439,228	18,130	1,457,358	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,484,997	105,344,591	136,829,588	-2,490	136,827,098	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	779,330	2,794,666	3,573,996	1,150	3,575,146	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	11,783	11,783	0	11,783	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	GIFT SHOP	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	185,154	39,265	224,419	1,340	225,759	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	32,449,481	108,190,305	140,639,786	0	140,639,786	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A | Date/Time Prepared: 11/28/2021 9:22 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-494,862	3,211,334		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-8,140	3,829,046		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	57,014	7,602,764		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,235,998	33,337,286		5.00
7.00	00700	OPERATION OF PLANT	-45,152	4,139,735		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	460,482		8.00
9.00	00900	HOUSEKEEPING	0	1,525,248		9.00
10.00	01000	DIETARY	-74,930	1,109,203		10.00
11.00	01100	CAFETERIA	-338,109	727,785		11.00
13.00	01300	NURSING ADMINISTRATION	-9,001	1,919,887		13.00
15.00	01500	PHARMACY	0	14,420,551		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-744	-354		16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	-23,747	185,834		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	6,691,004		30.00
31.00	03100	INTENSIVE CARE UNIT	-9,871	2,166,347		31.00
41.00	04100	SUBPROVIDER - IRF	0	1,288,701		41.00
43.00	04300	NURSERY	0	400,367		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,789,383		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-38	1,698,224		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-187,236	2,004,809		54.00
54.01	03630	ULTRA SOUND	0	302,729		54.01
56.00	05600	RADIOISOTOPE	-57	1,024,852		56.00
57.00	05700	CT SCAN	0	549,769		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	335,666		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	18,196		59.00
60.00	06000	LABORATORY	0	6,209,093		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,257,091		65.00
66.00	06600	PHYSICAL THERAPY	-4,630	2,871,488		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	706,986		67.00
68.00	06800	SPEECH PATHOLOGY	0	260,143		68.00
69.00	06900	ELECTROCARDIOLOGY	0	377,362		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	633,506		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,510,672		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,075,897		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,090,829		73.00
74.00	07400	RENAL DIALYSIS	0	213,599		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-29,736	741,514		76.00
76.01	03190	CHEMOTHERAPY	-5,378	3,870,158		76.01
76.02	03330	ENDOSCOPY	0	48,262		76.02
76.03	03950	WOUND CARE CENTER	0	906,229		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-8,455	256,830		90.00
91.00	09100	EMERGENCY	0	2,182,163		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	1,457,358		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-10,419,070	126,408,028		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,575,146		192.00
192.01	19201	ASC MOB	0	0		192.01
192.02	19202	EDUCATION CENTER	0	11,783		192.02
192.03	19203	MARKETING	0	0		192.03
194.00	07950	FOUNDATION	0	0		194.00
194.01	07951	GIFT SHOP	0	0		194.01
194.02	07952	CLINIC OF HOPE	0	225,759		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-10,419,070	130,220,716		200.00

RECLASSIFICATIONS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-6 | Date/Time Prepared: 11/28/2021 9:22 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LAUNDRY RECLASS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	460,482	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
	0		0	460,482	
	B - NURSERY RECLASS				
1.00	NURSERY	43.00	340,878	59,489	1.00
	0		340,878	59,489	
	C - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	0	1,040,205	1.00
	0		0	1,040,205	
	D - INTEREST EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,261	1.00
	0		0	6,261	
	E - CHEMOTHERAPY DRUG RECLASS				
1.00	PHARMACY	15.00	0	12,682,325	1.00
	0		0	12,682,325	
	F - PT-OT-ST RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	613,506	93,480	1.00
2.00	SPEECH PATHOLOGY	68.00	225,746	34,397	2.00
	0		839,252	127,877	
	G - ALLIED HEALTH RADIOLOGY TECH PROGRAM				
1.00	ALLIED HEALTH RAD. TECH PROGRAM	23.00	94,467	0	1.00
	0		94,467	0	
	H - SALARY PTO ACCRUAL				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,328	0	1.00
	TOTALS		1,328	0	
	I - PANDEMIC RECLASS				
1.00	NURSING ADMINISTRATION	13.00	1,026	0	1.00
2.00	PHARMACY	15.00	571	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	514	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	2,216	0	4.00
5.00	OPERATING ROOM	50.00	2,874	0	5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	2,384	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	706	0	7.00
8.00	ULTRA SOUND	54.01	1,899	0	8.00
9.00	RESPIRATORY THERAPY	65.00	4,499	0	9.00
10.00	PHYSICAL THERAPY	66.00	974	0	10.00
11.00	ELECTROCARDIOLOGY	69.00	575	0	11.00
12.00	ELECTROENCEPHALOGRAPHY	70.00	780	0	12.00
13.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	747	0	13.00
	TOTALS		19,765	0	
	J - STARP RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	182	0	1.00
2.00	NURSING ADMINISTRATION	13.00	22,795	0	2.00
3.00	PHARMACY	15.00	23,428	0	3.00
4.00	ALLIED HEALTH RAD. TECH PROGRAM	23.00	1,197	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	85,336	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	27,429	0	6.00
7.00	SUBPROVIDER - IRF	41.00	16,723	0	7.00
8.00	OPERATING ROOM	50.00	36,482	0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	26,229	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	21,915	0	10.00
11.00	ULTRA SOUND	54.01	4,080	0	11.00
12.00	RADIOISOTOPE	56.00	9,786	0	12.00
13.00	CT SCAN	57.00	7,282	0	13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	4,490	0	14.00
15.00	CARDIAC CATHETERIZATION	59.00	77	0	15.00
16.00	RESPIRATORY THERAPY	65.00	16,096	0	16.00
17.00	PHYSICAL THERAPY	66.00	50,467	0	17.00
18.00	ELECTROCARDIOLOGY	69.00	4,274	0	18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	6,530	0	19.00
20.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	3,005	0	20.00
21.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	10,157	0	21.00
22.00	CHEMOTHERAPY	76.01	10,279	0	22.00

RECLASSIFICATIONS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-6 | Date/Time Prepared: 11/28/2021 9:22 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
23.00	ENDOSCOPY	76.02	199	0	23.00
24.00	WOUND CARE CENTER	76.03	2,732	0	24.00
25.00	EMERGENCY	91.00	24,323	0	25.00
26.00	AMBULANCE SERVICES	95.00	18,130	0	26.00
27.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,150	0	27.00
28.00	CLINIC OF HOPE	194.02	1,340	0	28.00
	TOTALS		436,113	0	
	K - FURLOUGH RECLASS				
1.00	NURSING ADMINISTRATION	13.00	0	599	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	2,216	2.00
3.00	OPERATING ROOM	50.00	0	892	3.00
4.00	RESPIRATORY THERAPY	65.00	0	4,136	4.00
5.00	ELECTROCARDIOLOGY	69.00	0	575	5.00
6.00	ELECTROENCEPHALOGRAPHY	70.00	0	780	6.00
	TOTALS		0	9,198	
	L - PYC RECLASS				
1.00			0	0	1.00
			0	0	
	M - VCN RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,441	0	1.00
2.00	NURSING ADMINISTRATION	13.00	394	0	2.00
3.00	PHARMACY	15.00	280	0	3.00
4.00	OPERATING ROOM	50.00	132	0	4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	783	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	111	0	6.00
7.00	CT SCAN	57.00	833	0	7.00
8.00	RESPIRATORY THERAPY	65.00	1,010	0	8.00
	TOTALS		4,984	0	
	N - SYSTEM PROJECTS RECLASS				
1.00	NURSING ADMINISTRATION	13.00	61,152	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	81,536	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	30,276	0	3.00
4.00	SUBPROVIDER - IRF	41.00	32,858	0	4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	41,848	0	5.00
6.00	OPERATING ROOM	50.00	733	0	6.00
7.00	EMERGENCY	91.00	44	0	7.00
	TOTALS		248,447	0	
	O - PANDEMIC OTHER COSTS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	47,058	1.00
2.00	OPERATION OF PLANT	7.00	0	17,683	2.00
3.00	HOUSEKEEPING	9.00	0	6,135	3.00
4.00	CAFETERIA	11.00	0	25,689	4.00
	TOTALS		0	96,565	
	P - VCN TO WORKERS COMPENSATION				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,442	1.00
2.00	NURSING ADMINISTRATION	13.00	0	394	2.00
3.00	PHARMACY	15.00	0	280	3.00
4.00	OPERATING ROOM	50.00	0	132	4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	783	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	111	6.00
7.00	CT SCAN	57.00	0	833	7.00
8.00	RESPIRATORY THERAPY	65.00	0	1,010	8.00
	TOTALS		0	4,985	
500.00	Grand Total: Increases		1,985,234	14,487,387	500.00

RECLASSIFICATIONS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-6 | Date/Time Prepared: 11/28/2021 9:22 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LAUNDRY RECLASS						
1.00	ELECTROENCEPHALOGRAPHY	70.00	0	10,397	0		1.00
2.00	PHYSICAL THERAPY	66.00	0	35,588	0		2.00
3.00	CHEMOTHERAPY	76.01	0	1,123	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,076	0		4.00
5.00	HOUSEKEEPING	9.00	0	403,069	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	229	0		6.00
	0		0	460,482			
	B - NURSERY RECLASS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	340,878	59,489	0		1.00
	0		340,878	59,489			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	0	1,040,205	0		1.00
	0		0	1,040,205			
	D - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,261	11		1.00
	0		0	6,261			
	E - CHEMOTHERAPY DRUG RECLASS						
1.00	CHEMOTHERAPY	76.01	0	12,682,325	0		1.00
	0		0	12,682,325			
	F - PT-OT-ST RECLASS						
1.00	PHYSICAL THERAPY	66.00	839,252	127,877	0		1.00
2.00		0.00	0	0	0		2.00
	0		839,252	127,877			
	G - ALLIED HEALTH RADIOLOGY TECH PROGRAM						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	94,467	0	0		1.00
	0		94,467	0			
	H - SALARY PTO ACCRUAL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,328	0		1.00
	TOTALS		0	1,328			
	I - PANDEMIC RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	19,765	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
	TOTALS		19,765	0			
	J - STARP RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	436,113	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00

RECLASSIFICATIONS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-6 | Date/Time Prepared: 11/28/2021 9:22 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	TOTALS		436,113	0			
	K - FURLOUGH RECLASS						
1.00	NURSING ADMINISTRATION	13.00	599	0	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	2,216	0	0		2.00
3.00	OPERATING ROOM	50.00	892	0	0		3.00
4.00	RESPIRATORY THERAPY	65.00	4,136	0	0		4.00
5.00	ELECTROCARDIOLOGY	69.00	575	0	0		5.00
6.00	ELECTROENCEPHALOGRAPHY	70.00	780	0	0		6.00
	TOTALS		9,198	0			
	L - PYC RECLASS						
1.00			0	0			1.00
			0	0			
	M - VCN RECLASS						
1.00	CLINIC	90.00	4,984	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	TOTALS		4,984	0			
	N - SYSTEM PROJECTS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	248,447	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	TOTALS		248,447	0			
	O - PANDEMIC OTHER COSTS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	96,565	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	96,565			
	P - VCN TO WORKERS COMPENSATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,442	0	0		1.00
2.00	NURSING ADMINISTRATION	13.00	394	0	0		2.00
3.00	PHARMACY	15.00	280	0	0		3.00
4.00	OPERATING ROOM	50.00	132	0	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	783	0	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	111	0	0		6.00
7.00	CT SCAN	57.00	833	0	0		7.00
8.00	RESPIRATORY THERAPY	65.00	1,010	0	0		8.00
	TOTALS		4,985	0			
500.00	Grand Total: Decreases		1,998,089	14,474,532			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part I | Date/Time Prepared: 11/28/2021 9:22 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	525,279	150,000	0	150,000	3,360	1.00
2.00	Land Improvements	1,764,978	172,095	0	172,095	2,351	2.00
3.00	Buildings and Fixtures	54,684,558	31,386	0	31,386	2,350	3.00
4.00	Building Improvements	22,347,632	5,795,955	0	5,795,955	178,661	4.00
5.00	Fixed Equipment	21,924,420	0	0	0	840,679	5.00
6.00	Movable Equipment	50,389,889	5,705,440	0	5,705,440	2,659,646	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	151,636,756	11,854,876	0	11,854,876	3,687,047	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	151,636,756	11,854,876	0	11,854,876	3,687,047	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	671,919	0	1.00
2.00	Land Improvements	1,934,722	0	2.00
3.00	Buildings and Fixtures	54,713,594	0	3.00
4.00	Building Improvements	27,964,926	0	4.00
5.00	Fixed Equipment	21,083,741	0	5.00
6.00	Movable Equipment	53,435,683	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	159,804,585	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	159,804,585	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part II | Date/Time Prepared: 11/28/2021 9:22 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	2,754,494	423,688	501,123	0	33,152	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,797,363	39,823	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,551,857	463,511	501,123	0	33,152	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	3,712,457		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,837,186		2.00
3.00	Total (sum of lines 1-2)	0	7,549,643		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part III Date/Time Prepared: 11/28/2021 9:22 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	98,956,610	0	98,956,610	0.662597	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	50,389,889	0	50,389,889	0.337403	0	2.00
3.00	Total (sum of lines 1-2)	149,346,499	0	149,346,499	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,754,494	423,688	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,789,223	39,823	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,543,717	463,511	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	33,152	0	3,211,334	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,829,046	2.00
3.00	Total (sum of lines 1-2)	0	0	33,152	0	7,040,380	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8 | Date/Time Prepared: 11/28/2021 9:22 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-494,862	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-45,626	ADMINISTRATIVE & GENERAL	5.00	11	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,392	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-839,039			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	OPERATION OF PLANT	7.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	6,155,357			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-338,109	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-744	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
19.02	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.02
20.00	Vending machines	B	-197	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8 | Date/Time Prepared: 11/28/2021 9:22 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	LATE PENALTY FEES	B	0	WOUND CARE CENTER	76.03	0	33.00
33.02	BUILDING RENTAL INCOME	B	-24,518	OPERATION OF PLANT	7.00	0	33.02
33.03	BUILDING RENTAL INCOME	B	-16,298	OPERATION OF PLANT	7.00	0	33.03
33.04	BUILDING RENTAL INCOME	B	-68	OPERATION OF PLANT	7.00	0	33.04
33.08	MISCELLANEOUS INCOME	B	1,583	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	MISCELLANEOUS INCOME	B	-291	OPERATION OF PLANT	7.00	0	33.09
33.10	MISCELLANEOUS INCOME	B	-2,785	PHYSICAL THERAPY	66.00	0	33.10
33.11	MISCELLANEOUS INCOME	B	-375	RADIOLOGY-DIAGNOSTIC	54.00	0	33.11
33.12	MISCELLANEOUS INCOME	B	-1,165	PHYSICAL THERAPY	66.00	0	33.12
33.13	MISCELLANEOUS INCOME	B	-680	PHYSICAL THERAPY	66.00	0	33.13
33.18	MEALS ON WHEELS	B	-74,733	DIETARY	10.00	0	33.18
33.19	MEDICAL STAFF DUES	B	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.19
33.20	SEMINARS AND TUITION REVENUE	B	-23,747	ALLIED HEALTH RAD. TECH PROGRAM	23.00	0	33.20
33.23	GAIN ON DISPOSAL OF ASSETS	B	-8,140	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.23
33.24	LOBBYING EXPENSES	A	-1,672	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	PROVIDER TAX ASSESSMENT	A	-10,430,245	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	TELEVISION EXPENSE	A	-3,977	OPERATION OF PLANT	7.00	0	33.26
33.27	BAD DEBT NON PATIENT RELATED	A	-4,980	CHEMOTHERAPY	76.01	0	33.27
33.28	ENTERTAINMENT EXPENSE	A	-38	DELIVERY ROOM & LABOR ROOM	52.00	0	33.28
33.29	ENTERTAINMENT EXPENSE	A	-60	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	33.29
33.30	ENTERTAINMENT EXPENSE	A	-57	RADIOISOTOPE	56.00	0	33.30
33.31	ENTERTAINMENT EXPENSE	A	-398	CHEMOTHERAPY	76.01	0	33.31
33.32	ADVERTISING	A	-350	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	ADVERTISING	A	-9,001	NURSING ADMINISTRATION	13.00	0	33.33
33.34	PHYSICIAN FUNDING OFFSET	A	-4,225,637	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	MID LEVEL PROVIDER OFFSET	A	-9,871	INTENSIVE CARE UNIT	31.00	0	33.35
33.36	MID LEVEL PROVIDER OFFSET	A	-500	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	33.36
33.37	MID LEVEL PROVIDER OFFSET	A	-8,455	CLINIC	90.00	0	33.37
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,419,070				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-1 | Date/Time Prepared: 11/28/2021 9:22 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSUJRANCE	5,947,867	5,890,853	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE CAPITAL	2,221,240	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST EXPENSE	39,365	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE OTHER	29,123,159	25,286,153	3.01
3.02	15.00	PHARMACY	SVH CHARGEBACK	-24,000	-24,000	3.02
3.03	23.00	ALLIED HEALTH RAD. TECH PROG	SVH CHARGEBACK	28,370	28,370	3.03
3.04	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACK	100,546	100,546	3.04
3.05	56.00	RADIOISOTOPE	SVH CHARGEBACK	10,437	10,437	3.05
3.06	59.00	CARDIAC CATHETERIZATION	SVH CHARGEBACK	5,000	5,000	3.06
3.07	69.00	ELECTROCARDIOLOGY	SVH CHARGEBACK	5,000	5,000	3.07
3.08	91.00	EMERGENCY	SVH CHARGEBACK	-100	-100	3.08
3.09	192.00	PHYSICIANS' PRIVATE OFFICES	SVH CHARGEBACK	2,601,650	2,601,650	3.09
3.10	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	494,862	494,862	3.10
4.00	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE A&G	732	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE A&G	6,261	6,261	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			40,560,389	34,405,032	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B		0.00	SVH HOME OFFICE	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0010	Period: From 07/01/2020 To 06/30/2021	Worksheet A-8-1 Date/Time Prepared: 11/28/2021 9:22 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	57,014	0		1.00
2.00	2,221,240	0		2.00
3.00	39,365	0		3.00
3.01	3,837,006	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	11		3.10
4.00	732	0		4.00
4.01	0	0		4.01
5.00	6,155,357			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-2 | Date/Time Prepared: 11/28/2021 9:22 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	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	29,176	29,176	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	186,861	186,861	0	0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	1,223,560	623,002	600,558	211,500	9,235	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,439,597	839,039	600,558		9,235	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	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	939,040	46,952	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			939,040	46,952	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	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	29,176		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	186,861		2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	0	939,040	0	623,002		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	939,040	0	839,039		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I Date/Time Prepared: 11/28/2021 9:22 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,211,334	3,211,334				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,829,046		3,829,046			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,602,764	124,216	0	7,726,980		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	33,337,286	485,558	19,420	405,953	34,248,217	5.00
7.00	00700	OPERATION OF PLANT	4,139,735	445,610	101,870	0	4,687,215	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	460,482	5,019	0	0	465,501	8.00
9.00	00900	HOUSEKEEPING	1,525,248	19,524	0	0	1,544,772	9.00
10.00	01000	DIETARY	1,109,203	50,433	13,245	0	1,172,881	10.00
11.00	01100	CAFETERIA	727,785	61,139	11,686	0	800,610	11.00
13.00	01300	NURSING ADMINISTRATION	1,919,887	52,913	166,281	381,524	2,520,605	13.00
15.00	01500	PHARMACY	14,420,551	30,996	0	372,193	14,823,740	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-354	23,710	3,413	0	26,769	16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	185,834	8,682	0	41,996	236,512	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,691,004	285,291	109,668	1,392,546	8,478,509	30.00
31.00	03100	INTENSIVE CARE UNIT	2,166,347	54,609	60,848	450,904	2,732,708	31.00
41.00	04100	SUBPROVIDER - IRF	1,288,701	131,464	550	276,934	1,697,649	41.00
43.00	04300	NURSERY	400,367	15,590	17,835	82,076	515,868	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,789,383	316,345	446,031	587,525	6,139,284	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,698,224	31,626	72,477	350,506	2,152,833	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,004,809	230,808	814,190	333,942	3,383,749	54.00
54.01	03630	ULTRA SOUND	302,729	0	106,457	66,087	475,273	54.01
56.00	05600	RADIOISOTOPE	1,024,852	19,379	542,247	157,427	1,743,905	56.00
57.00	05700	CT SCAN	549,769	0	925	117,146	667,840	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	335,666	0	264,393	72,224	672,283	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,196	3,876	15,581	1,238	38,891	59.00
60.00	06000	LABORATORY	6,209,093	76,545	3,016	0	6,288,654	60.00
65.00	06500	RESPIRATORY THERAPY	1,257,091	11,986	34,671	259,013	1,562,761	65.00
66.00	06600	PHYSICAL THERAPY	2,871,488	69,908	22,538	610,011	3,573,945	66.00
67.00	06700	OCCUPATIONAL THERAPY	706,986	29,998	5,570	147,718	890,272	67.00
68.00	06800	SPEECH PATHOLOGY	260,143	10,077	2,050	54,354	326,624	68.00
69.00	06900	ELECTROCARDIOLOGY	377,362	38,786	155,295	68,758	640,201	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	633,506	26,432	19,360	105,045	784,343	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,510,672	41,751	98,430	48,516	1,699,369	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,075,897	0	0	0	3,075,897	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,090,829	0	34,798	0	6,125,627	73.00
74.00	07400	RENAL DIALYSIS	213,599	0	0	0	213,599	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	741,514	44,483	12,041	165,171	963,209	76.00
76.01	03190	CHEMOTHERAPY	3,870,158	29,068	370,173	163,697	4,433,096	76.01
76.02	03330	ENDOSCOPY	48,262	0	10,727	3,201	62,190	76.02
76.03	03950	WOUND CARE CENTER	906,229	0	9,065	43,941	959,235	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	256,830	0	0	51,560	308,390	90.00
91.00	09100	EMERGENCY	2,182,163	187,390	61,468	391,306	2,822,327	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,457,358	38,447	202,485	291,643	1,989,933	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	126,408,028	3,001,659	3,808,804	7,494,155	125,945,286	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,575,146	197,961	20,242	187,922	3,981,271	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	11,783	0	0	0	11,783	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	GIFT SHOP	0	9,970	0	0	9,970	194.01
194.02	07952	CLINIC OF HOPE	225,759	1,744	0	44,903	272,406	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	130,220,716	3,211,334	3,829,046	7,726,980	130,220,716	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I Date/Time Prepared: 11/28/2021 9:22 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	34,248,217					5.00
7.00	00700	OPERATION OF PLANT	1,672,651	6,359,866				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	166,116	14,806	646,423			8.00
9.00	00900	HOUSEKEEPING	551,258	57,594	198,488	2,352,112		9.00
10.00	01000	DIETARY	418,547	148,772	0	0	1,740,200	10.00
11.00	01100	CAFETERIA	285,701	180,356	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	899,488	156,089	0	1,801	0	13.00
15.00	01500	PHARMACY	5,289,958	91,435	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,553	69,941	0	600	0	16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	84,400	25,610	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,025,590	841,583	206,441	684,383	1,086,415	30.00
31.00	03100	INTENSIVE CARE UNIT	975,178	161,091	55,039	180,100	208,221	31.00
41.00	04100	SUBPROVIDER - IRF	605,813	387,808	5,407	180,100	332,090	41.00
43.00	04300	NURSERY	184,090	45,989	8,443	96,486	113,474	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,190,828	933,191	6,468	360,201	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	768,247	93,293	22,887	245,705	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,207,504	680,864	15,151	36,620	0	54.00
54.01	03630	ULTRA SOUND	169,603	0	3,984	7,804	0	54.01
56.00	05600	RADIOISOTOPE	622,319	57,165	0	27,015	0	56.00
57.00	05700	CT SCAN	238,321	0	7,252	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	239,907	0	1,902	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,878	11,433	0	12,007	0	59.00
60.00	06000	LABORATORY	2,244,131	225,802	476	74,442	0	60.00
65.00	06500	RESPIRATORY THERAPY	557,678	35,357	438	3,602	0	65.00
66.00	06600	PHYSICAL THERAPY	1,275,377	206,223	0	8,020	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	317,697	88,491	0	4,454	0	67.00
68.00	06800	SPEECH PATHOLOGY	116,557	29,726	405	8,537	0	68.00
69.00	06900	ELECTROCARDIOLOGY	228,458	114,416	0	4,803	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	279,896	77,973	0	30,617	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	606,427	123,162	10,196	67,238	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,097,646	0	45	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,185,954	0	71	27,015	0	73.00
74.00	07400	RENAL DIALYSIS	76,224	0	0	12,007	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	343,725	131,222	3,642	24,013	0	76.00
76.01	03190	CHEMOTHERAPY	1,581,968	85,748	0	0	0	76.01
76.02	03330	ENDOSCOPY	22,193	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	342,307	0	0	38,421	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	110,050	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,007,159	552,786	98,855	216,121	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	710,116	113,415	833	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,722,513	5,741,341	646,423	2,352,112	1,740,200	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,420,732	583,969	0	0	0	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	4,205	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	GIFT SHOP	3,558	29,411	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	97,209	5,145	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	34,248,217	6,359,866	646,423	2,352,112	1,740,200	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I | Date/Time Prepared: 11/28/2021 9:22 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	ALLIED HEALTH RAD. TECH PROGRAM	
			11.00	13.00	15.00	16.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,266,667					11.00
13.00	01300	NURSING ADMINISTRATION	69,647	3,647,630				13.00
15.00	01500	PHARMACY	48,678	17,543	20,271,354			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	106,863		16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	7,279	0	0	0	353,801	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	278,417	1,295,390	0	5,328	0	30.00
31.00	03100	INTENSIVE CARE UNIT	78,180	413,041	0	2,012	0	31.00
41.00	04100	SUBPROVIDER - IRF	58,163	268,934	0	1,474	0	41.00
43.00	04300	NURSERY	14,236	102,123	0	502	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	112,097	499,328	0	17,174	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	62,362	415,010	0	3,172	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,283	5,838	0	4,515	121,824	54.00
54.01	03630	ULTRA SOUND	9,163	0	0	1,281	34,561	54.01
56.00	05600	RADIOISOTOPE	28,398	24,424	0	4,186	112,933	56.00
57.00	05700	CT SCAN	18,147	6,525	0	2,518	67,937	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,879	0	0	613	16,546	58.00
59.00	05900	CARDIAC CATHETERIZATION	198	1,078	0	71	0	59.00
60.00	06000	LABORATORY	0	0	0	15,421	0	60.00
65.00	06500	RESPIRATORY THERAPY	50,779	15,078	0	2,435	0	65.00
66.00	06600	PHYSICAL THERAPY	106,302	0	0	2,589	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,253	0	0	963	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,660	0	0	215	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,109	20,508	0	2,606	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	21,170	0	0	1,302	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,161	0	0	3,034	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,208	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	20,265,330	12,893	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	204	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	37,189	26,119	0	891	0	76.00
76.01	03190	CHEMOTHERAPY	28,115	92,136	0	1,342	0	76.01
76.02	03330	ENDOSCOPY	414	8,099	0	63	0	76.02
76.03	03950	WOUND CARE CENTER	9,531	30,582	0	3,023	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,229	2,226	0	0	0	90.00
91.00	09100	EMERGENCY	72,719	372,152	0	12,670	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	17,904	0	2,158	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,258,758	3,634,038	20,265,330	106,863	353,801	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	390	2,742	0	0	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	GIFT SHOP	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	7,909	13,202	3,282	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,266,667	3,647,630	20,271,354	106,863	353,801	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I Date/Time Prepared: 11/28/2021 9:22 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	15,902,056	0	15,902,056		30.00
31.00	03100	INTENSIVE CARE UNIT	4,805,570	0	4,805,570		31.00
41.00	04100	SUBPROVIDER - IRF	3,537,438	0	3,537,438		41.00
43.00	04300	NURSERY	1,081,211	0	1,081,211		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	10,258,571	0	10,258,571		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,763,509	0	3,763,509		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,520,348	0	5,520,348		54.00
54.01	03630	ULTRA SOUND	701,669	0	701,669		54.01
56.00	05600	RADIOISOTOPE	2,620,345	0	2,620,345		56.00
57.00	05700	CT SCAN	1,008,540	0	1,008,540		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	942,130	0	942,130		58.00
59.00	05900	CARDIAC CATHETERIZATION	77,556	0	77,556		59.00
60.00	06000	LABORATORY	8,848,926	0	8,848,926		60.00
65.00	06500	RESPIRATORY THERAPY	2,228,128	0	2,228,128		65.00
66.00	06600	PHYSICAL THERAPY	5,172,456	0	5,172,456		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,328,130	0	1,328,130		67.00
68.00	06800	SPEECH PATHOLOGY	491,724	0	491,724		68.00
69.00	06900	ELECTROCARDIOLOGY	1,023,101	0	1,023,101		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,195,301	0	1,195,301		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,525,587	0	2,525,587		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,175,796	0	4,175,796		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,616,890	0	28,616,890		73.00
74.00	07400	RENAL DIALYSIS	302,034	0	302,034		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,530,010	0	1,530,010		76.00
76.01	03190	CHEMOTHERAPY	6,222,405	0	6,222,405		76.01
76.02	03330	ENDOSCOPY	92,959	0	92,959		76.02
76.03	03950	WOUND CARE CENTER	1,383,099	0	1,383,099		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	428,895	0	428,895		90.00
91.00	09100	EMERGENCY	5,154,789	0	5,154,789		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,834,359	0	2,834,359		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	123,773,532	0	123,773,532		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,989,104	0	5,989,104		192.00
192.01	19201	ASC MOB	0	0	0		192.01
192.02	19202	EDUCATION CENTER	15,988	0	15,988		192.02
192.03	19203	MARKETING	0	0	0		192.03
194.00	07950	FOUNDATION	0	0	0		194.00
194.01	07951	GIFT SHOP	42,939	0	42,939		194.01
194.02	07952	CLINIC OF HOPE	399,153	0	399,153		194.02
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)	130,220,716	0	130,220,716		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II Date/Time Prepared: 11/28/2021 9:22 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	124,216	0	124,216	124,216	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,221,240	485,558	19,420	2,726,218	6,527	5.00
7.00	00700	OPERATION OF PLANT	0	445,610	101,870	547,480	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,019	0	5,019	0	8.00
9.00	00900	HOUSEKEEPING	0	19,524	0	19,524	0	9.00
10.00	01000	DIETARY	0	50,433	13,245	63,678	0	10.00
11.00	01100	CAFETERIA	0	61,139	11,686	72,825	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	52,913	166,281	219,194	6,134	13.00
15.00	01500	PHARMACY	0	30,996	0	30,996	5,984	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,710	3,413	27,123	0	16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	0	8,682	0	8,682	675	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	285,291	109,668	394,959	22,378	30.00
31.00	03100	INTENSIVE CARE UNIT	0	54,609	60,848	115,457	7,249	31.00
41.00	04100	SUBPROVIDER - IRF	0	131,464	550	132,014	4,452	41.00
43.00	04300	NURSERY	0	15,590	17,835	33,425	1,320	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	316,345	446,031	762,376	9,446	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	31,626	72,477	104,103	5,635	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	230,808	814,190	1,044,998	5,369	54.00
54.01	03630	ULTRA SOUND	0	0	106,457	106,457	1,062	54.01
56.00	05600	RADIOISOTOPE	0	19,379	542,247	561,626	2,531	56.00
57.00	05700	CT SCAN	0	0	925	925	1,883	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	264,393	264,393	1,161	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,876	15,581	19,457	20	59.00
60.00	06000	LABORATORY	0	76,545	3,016	79,561	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,986	34,671	46,657	4,164	65.00
66.00	06600	PHYSICAL THERAPY	0	69,908	22,538	92,446	9,807	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	29,998	5,570	35,568	2,375	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,077	2,050	12,127	874	68.00
69.00	06900	ELECTROCARDIOLOGY	0	38,786	155,295	194,081	1,105	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	26,432	19,360	45,792	1,689	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,751	98,430	140,181	780	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	34,798	34,798	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	44,483	12,041	56,524	2,655	76.00
76.01	03190	CHEMOTHERAPY	0	29,068	370,173	399,241	2,632	76.01
76.02	03330	ENDOSCOPY	0	0	10,727	10,727	51	76.02
76.03	03950	WOUND CARE CENTER	0	0	9,065	9,065	706	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	829	90.00
91.00	09100	EMERGENCY	0	187,390	61,468	248,858	6,291	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	38,447	202,485	240,932	4,689	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,221,240	3,001,659	3,808,804	9,031,703	120,473	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	197,961	20,242	218,203	3,021	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	GIFT SHOP	0	9,970	0	9,970	0	194.01
194.02	07952	CLINIC OF HOPE	0	1,744	0	1,744	722	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,221,240	3,211,334	3,829,046	9,261,620	124,216	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II Date/Time Prepared: 11/28/2021 9:22 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,732,745					5.00
7.00	00700	OPERATION OF PLANT	133,464	680,944				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,255	1,585	19,859			8.00
9.00	00900	HOUSEKEEPING	43,986	6,167	6,098	75,775		9.00
10.00	01000	DIETARY	33,397	15,929	0	0	113,004	10.00
11.00	01100	CAFETERIA	22,797	19,310	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	71,772	16,712	0	58	0	13.00
15.00	01500	PHARMACY	422,114	9,790	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	762	7,489	0	19	0	16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	6,734	2,742	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	241,417	90,107	6,344	22,049	70,549	30.00
31.00	03100	INTENSIVE CARE UNIT	77,811	17,248	1,691	5,802	13,521	31.00
41.00	04100	SUBPROVIDER - IRF	48,339	41,522	166	5,802	21,565	41.00
43.00	04300	NURSERY	14,689	4,924	259	3,108	7,369	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	174,810	99,916	199	11,604	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	61,300	9,989	703	7,916	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96,349	72,899	465	1,180	0	54.00
54.01	03630	ULTRA SOUND	13,533	0	122	251	0	54.01
56.00	05600	RADIOISOTOPE	49,656	6,121	0	870	0	56.00
57.00	05700	CT SCAN	19,016	0	223	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	19,143	0	58	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,107	1,224	0	387	0	59.00
60.00	06000	LABORATORY	179,063	24,176	15	2,398	0	60.00
65.00	06500	RESPIRATORY THERAPY	44,498	3,786	13	116	0	65.00
66.00	06600	PHYSICAL THERAPY	101,765	22,080	0	258	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,350	9,475	0	144	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,300	3,183	12	275	0	68.00
69.00	06900	ELECTROCARDIOLOGY	18,229	12,250	0	155	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	22,333	8,348	0	986	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,388	13,187	313	2,166	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	87,583	0	1	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	174,421	0	2	870	0	73.00
74.00	07400	RENAL DIALYSIS	6,082	0	0	387	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	27,426	14,050	112	774	0	76.00
76.01	03190	CHEMOTHERAPY	126,228	9,181	0	0	0	76.01
76.02	03330	ENDOSCOPY	1,771	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	27,313	0	0	1,238	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,781	0	0	0	0	90.00
91.00	09100	EMERGENCY	80,363	59,186	3,037	6,962	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	56,661	12,143	26	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,611,006	614,719	19,859	75,775	113,004	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	113,363	62,525	0	0	0	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	336	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	GIFT SHOP	284	3,149	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	7,756	551	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,732,745	680,944	19,859	75,775	113,004	202.00

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		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	ALLIED HEALTH RAD. TECH PROGRAM	
			11.00	13.00	15.00	16.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	114,932					11.00
13.00	01300	NURSING ADMINISTRATION	6,319	320,189				13.00
15.00	01500	PHARMACY	4,417	1,540	474,841			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	35,276		16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	660	0	0	0	19,493	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,263	113,708	0	1,766		30.00
31.00	03100	INTENSIVE CARE UNIT	7,094	36,257	0	667		31.00
41.00	04100	SUBPROVIDER - IRF	5,277	23,607	0	488		41.00
43.00	04300	NURSERY	1,292	8,964	0	166		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,171	43,831	0	5,547		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,658	36,430	0	1,051		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,833	512	0	1,497		54.00
54.01	03630	ULTRA SOUND	831	0	0	425		54.01
56.00	05600	RADIOISOTOPE	2,577	2,144	0	1,388		56.00
57.00	05700	CT SCAN	1,647	573	0	835		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	987	0	0	203		58.00
59.00	05900	CARDIAC CATHETERIZATION	18	95	0	24		59.00
60.00	06000	LABORATORY	0	0	0	5,111		60.00
65.00	06500	RESPIRATORY THERAPY	4,607	1,324	0	807		65.00
66.00	06600	PHYSICAL THERAPY	9,645	0	0	858		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,382	0	0	319		67.00
68.00	06800	SPEECH PATHOLOGY	877	0	0	71		68.00
69.00	06900	ELECTROCARDIOLOGY	1,099	1,800	0	864		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,921	0	0	432		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,466	0	0	1,006		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	732		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	474,700	4,273		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	68		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,374	2,293	0	295		76.00
76.01	03190	CHEMOTHERAPY	2,551	8,088	0	445		76.01
76.02	03330	ENDOSCOPY	38	711	0	21		76.02
76.03	03950	WOUND CARE CENTER	865	2,684	0	1,002		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	747	195	0	0		90.00
91.00	09100	EMERGENCY	6,598	32,668	0	4,200		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,572	0	715		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,214	318,996	474,700	35,276	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	34	64	0		192.00
192.01	19201	ASC MOB	0	0	0	0		192.01
192.02	19202	EDUCATION CENTER	0	0	0	0		192.02
192.03	19203	MARKETING	0	0	0	0		192.03
194.00	07950	FOUNDATION	0	0	0	0		194.00
194.01	07951	GIFT SHOP	0	0	0	0		194.01
194.02	07952	CLINIC OF HOPE	718	1,159	77	0		194.02
200.00		Cross Foot Adjustments					19,493	200.00
201.00		Negative Cost Centers	0	0	0	117	0	201.00
202.00		TOTAL (sum lines 118 through 201)	114,932	320,189	474,841	35,393	19,493	202.00

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		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	988,540	0	988,540		30.00
31.00	03100	INTENSIVE CARE UNIT	282,797	0	282,797		31.00
41.00	04100	SUBPROVIDER - IRF	283,232	0	283,232		41.00
43.00	04300	NURSERY	75,516	0	75,516		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,117,900	0	1,117,900		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	232,785	0	232,785		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,229,102	0	1,229,102		54.00
54.01	03630	ULTRA SOUND	122,681	0	122,681		54.01
56.00	05600	RADIOISOTOPE	626,913	0	626,913		56.00
57.00	05700	CT SCAN	25,102	0	25,102		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	285,945	0	285,945		58.00
59.00	05900	CARDIAC CATHETERIZATION	22,332	0	22,332		59.00
60.00	06000	LABORATORY	290,324	0	290,324		60.00
65.00	06500	RESPIRATORY THERAPY	105,972	0	105,972		65.00
66.00	06600	PHYSICAL THERAPY	236,859	0	236,859		66.00
67.00	06700	OCCUPATIONAL THERAPY	75,613	0	75,613		67.00
68.00	06800	SPEECH PATHOLOGY	26,719	0	26,719		68.00
69.00	06900	ELECTROCARDIOLOGY	229,583	0	229,583		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	81,501	0	81,501		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	207,487	0	207,487		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,316	0	88,316		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	689,064	0	689,064		73.00
74.00	07400	RENAL DIALYSIS	6,537	0	6,537		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	107,503	0	107,503		76.00
76.01	03190	CHEMOTHERAPY	548,366	0	548,366		76.01
76.02	03330	ENDOSCOPY	13,319	0	13,319		76.02
76.03	03950	WOUND CARE CENTER	42,873	0	42,873		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	10,552	0	10,552		90.00
91.00	09100	EMERGENCY	448,163	0	448,163		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	316,738	0	316,738		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,818,334	0	8,818,334		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	397,210	0	397,210		192.00
192.01	19201	ASC MOB	0	0	0		192.01
192.02	19202	EDUCATION CENTER	336	0	336		192.02
192.03	19203	MARKETING	0	0	0		192.03
194.00	07950	FOUNDATION	0	0	0		194.00
194.01	07951	GIFT SHOP	13,403	0	13,403		194.01
194.02	07952	CLINIC OF HOPE	12,727	0	12,727		194.02
200.00		Cross Foot Adjustments	19,493	0	19,493		200.00
201.00		Negative Cost Centers	117	0	117		201.00
202.00		TOTAL (sum lines 118 through 201)	9,261,620	0	9,261,620		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/28/2021 9:22 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	331,432					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,144,193				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,820	0	32,091,797			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	50,113	10,875	1,686,013	-34,248,217	95,972,499	5.00
7.00	00700	OPERATION OF PLANT	45,990	57,045	0	0	4,687,215	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	518	0	0	0	465,501	8.00
9.00	00900	HOUSEKEEPING	2,015	0	0	0	1,544,772	9.00
10.00	01000	DIETARY	5,205	7,417	0	0	1,172,881	10.00
11.00	01100	CAFETERIA	6,310	6,544	0	0	800,610	11.00
13.00	01300	NURSING ADMINISTRATION	5,461	93,114	1,584,554	0	2,520,605	13.00
15.00	01500	PHARMACY	3,199	0	1,545,800	0	14,823,740	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,447	1,911	0	0	26,769	16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	896	0	174,417	0	236,512	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,444	61,412	5,783,493	0	8,478,509	30.00
31.00	03100	INTENSIVE CARE UNIT	5,636	34,074	1,872,704	0	2,732,708	31.00
41.00	04100	SUBPROVIDER - IRF	13,568	308	1,150,170	0	1,697,649	41.00
43.00	04300	NURSERY	1,609	9,987	340,878	0	515,868	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,649	249,769	2,440,123	0	6,139,284	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,264	40,586	1,455,728	0	2,152,833	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,821	455,931	1,386,934	0	3,383,749	54.00
54.01	03630	ULTRA SOUND	0	59,614	274,474	0	475,273	54.01
56.00	05600	RADIOISOTOPE	2,000	303,648	653,828	0	1,743,905	56.00
57.00	05700	CT SCAN	0	518	486,535	0	667,840	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	148,055	299,961	0	672,283	58.00
59.00	05900	CARDIAC CATHETERIZATION	400	8,725	5,140	0	38,891	59.00
60.00	06000	LABORATORY	7,900	1,689	0	0	6,288,654	60.00
65.00	06500	RESPIRATORY THERAPY	1,237	19,415	1,075,737	0	1,562,761	65.00
66.00	06600	PHYSICAL THERAPY	7,215	12,621	2,533,511	0	3,573,945	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,096	3,119	613,506	0	890,272	67.00
68.00	06800	SPEECH PATHOLOGY	1,040	1,148	225,746	0	326,624	68.00
69.00	06900	ELECTROCARDIOLOGY	4,003	86,962	285,567	0	640,201	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,728	10,841	436,276	0	784,343	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	55,119	201,496	0	1,699,369	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,075,897	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,486	0	0	6,125,627	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	213,599	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,591	6,743	685,991	0	963,209	76.00
76.01	03190	CHEMOTHERAPY	3,000	207,290	679,871	0	4,433,096	76.01
76.02	03330	ENDOSCOPY	0	6,007	13,293	0	62,190	76.02
76.03	03950	WOUND CARE CENTER	0	5,076	182,497	0	959,235	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	214,141	0	308,390	90.00
91.00	09100	EMERGENCY	19,340	34,421	1,625,180	0	2,822,327	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,968	113,388	1,211,259	0	1,989,933	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	309,792	2,132,858	31,124,823	-34,248,217	91,697,069	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,431	11,335	780,480	0	3,981,271	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	11,783	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	GIFT SHOP	1,029	0	0	0	9,970	194.01
194.02	07952	CLINIC OF HOPE	180	0	186,494	0	272,406	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,211,334	3,829,046	7,726,980		34,248,217	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.689270	1.785775	0.240777		0.356854	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			124,216		2,732,745	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/28/2021 9:22 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003871		0.028474	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: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/28/2021 9:22 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MANHOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	222,509					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	518	6,069,750				8.00
9.00	00900	HOUSEKEEPING	2,015	1,863,750	195,900			9.00
10.00	01000	DIETARY	5,205	0	0	21,930		10.00
11.00	01100	CAFETERIA	6,310	0	0	0	832,633	11.00
13.00	01300	NURSING ADMINISTRATION	5,461	0	150	0	45,782	13.00
15.00	01500	PHARMACY	3,199	0	0	0	31,998	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,447	0	50	0	0	16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	896	0	0	0	4,785	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,444	1,938,437	57,000	13,691	183,016	30.00
31.00	03100	INTENSIVE CARE UNIT	5,636	516,806	15,000	2,624	51,391	31.00
41.00	04100	SUBPROVIDER - IRF	13,568	50,773	15,000	4,185	38,233	41.00
43.00	04300	NURSERY	1,609	79,275	8,036	1,430	9,358	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,649	60,732	30,000	0	73,686	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,264	214,904	20,464	0	40,993	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,821	142,263	3,050	0	42,256	54.00
54.01	03630	ULTRA SOUND	0	37,410	650	0	6,023	54.01
56.00	05600	RADIOISOTOPE	2,000	0	2,250	0	18,667	56.00
57.00	05700	CT SCAN	0	68,092	0	0	11,929	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	17,855	0	0	7,151	58.00
59.00	05900	CARDIAC CATHETERIZATION	400	0	1,000	0	130	59.00
60.00	06000	LABORATORY	7,900	4,473	6,200	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,237	4,110	300	0	33,379	65.00
66.00	06600	PHYSICAL THERAPY	7,215	0	668	0	69,877	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,096	0	371	0	17,257	67.00
68.00	06800	SPEECH PATHOLOGY	1,040	3,804	711	0	6,350	68.00
69.00	06900	ELECTROCARDIOLOGY	4,003	0	400	0	7,960	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,728	0	2,550	0	13,916	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	95,734	5,600	0	10,623	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	421	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	669	2,250	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,000	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,591	34,199	2,000	0	24,446	76.00
76.01	03190	CHEMOTHERAPY	3,000	0	0	0	18,481	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	272	76.02
76.03	03950	WOUND CARE CENTER	0	0	3,200	0	6,265	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	5,409	90.00
91.00	09100	EMERGENCY	19,340	928,224	18,000	0	47,801	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,968	7,819	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	200,869	6,069,750	195,900	21,930	827,434	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,431	0	0	0	0	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	GIFT SHOP	1,029	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	180	0	0	0	5,199	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,359,866	646,423	2,352,112	1,740,200	1,266,667	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.582511	0.106499	12.006697	79.352485	1.521279	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	680,944	19,859	75,775	113,004	114,932	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.060299	0.003272	0.386804	5.152941	0.138034	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/28/2021 9:22 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MANHOURS)	
			7.00	8.00	9.00	10.00	11.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/28/2021 9:22 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH RAD. TECH PROGRAM (ASSIGNED TIME)		
			13.00	15.00	16.00	23.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	626,067					13.00
15.00	01500	PHARMACY	3,011	6,084,053				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	599,907,079			16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	0	0	0	73,675,161		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	222,336	0	29,930,300	0		30.00
31.00	03100	INTENSIVE CARE UNIT	70,893	0	11,304,427	0		31.00
41.00	04100	SUBPROVIDER - IRF	46,159	0	8,278,597	0		41.00
43.00	04300	NURSERY	17,528	0	2,821,564	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	85,703	0	96,032,215	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	71,231	0	17,820,941	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,002	0	25,366,624	25,366,624		54.00
54.01	03630	ULTRA SOUND	0	0	7,197,231	7,197,231		54.01
56.00	05600	RADIOISOTOPE	4,192	0	23,517,953	23,517,953		56.00
57.00	05700	CT SCAN	1,120	0	14,147,703	14,147,703		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	3,445,650	3,445,650		58.00
59.00	05900	CARDIAC CATHETERIZATION	185	0	399,044	0		59.00
60.00	06000	LABORATORY	0	0	86,632,234	0		60.00
65.00	06500	RESPIRATORY THERAPY	2,588	0	13,677,511	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	14,547,680	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,407,870	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,210,426	0		68.00
69.00	06900	ELECTROCARDIOLOGY	3,520	0	14,639,017	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	7,316,226	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	17,042,499	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	12,403,359	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,082,245	72,432,053	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	1,147,931	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,483	0	5,006,049	0		76.00
76.01	03190	CHEMOTHERAPY	15,814	0	7,542,084	0		76.01
76.02	03330	ENDOSCOPY	1,390	0	355,743	0		76.02
76.03	03950	WOUND CARE CENTER	5,249	0	16,980,427	0		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	382	0	0	0		90.00
91.00	09100	EMERGENCY	63,875	0	71,182,482	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,073	0	12,121,239	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	623,734	6,082,245	599,907,079	73,675,161		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	67	823	0	0		192.00
192.01	19201	ASC MOB	0	0	0	0		192.01
192.02	19202	EDUCATION CENTER	0	0	0	0		192.02
192.03	19203	MARKETING	0	0	0	0		192.03
194.00	07950	FOUNDATION	0	0	0	0		194.00
194.01	07951	GIFT SHOP	0	0	0	0		194.01
194.02	07952	CLINIC OF HOPE	2,266	985	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,647,630	20,271,354	106,863	353,801		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.826261	3.331883	0.000178	0.004802		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	320,189	474,841	35,393	19,493		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.511429	0.078047	0.000059	0.000265		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/28/2021 9:22 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH RAD. TECH PROGRAM (ASSIGNED TIME)		
			13.00	15.00	16.00	23.00		
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/28/2021 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,902,056		15,902,056	0	15,902,056	30.00
31.00	03100	INTENSIVE CARE UNIT	4,805,570		4,805,570	0	4,805,570	31.00
41.00	04100	SUBPROVIDER - IRF	3,537,438		3,537,438	0	3,537,438	41.00
43.00	04300	NURSERY	1,081,211		1,081,211	0	1,081,211	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,258,571		10,258,571	0	10,258,571	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,763,509		3,763,509	0	3,763,509	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,520,348		5,520,348	0	5,520,348	54.00
54.01	03630	ULTRA SOUND	701,669		701,669	0	701,669	54.01
56.00	05600	RADIOISOTOPE	2,620,345		2,620,345	0	2,620,345	56.00
57.00	05700	CT SCAN	1,008,540		1,008,540	0	1,008,540	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	942,130		942,130	0	942,130	58.00
59.00	05900	CARDIAC CATHETERIZATION	77,556		77,556	0	77,556	59.00
60.00	06000	LABORATORY	8,848,926		8,848,926	0	8,848,926	60.00
65.00	06500	RESPIRATORY THERAPY	2,228,128	0	2,228,128	0	2,228,128	65.00
66.00	06600	PHYSICAL THERAPY	5,172,456	0	5,172,456	0	5,172,456	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,328,130	0	1,328,130	0	1,328,130	67.00
68.00	06800	SPEECH PATHOLOGY	491,724	0	491,724	0	491,724	68.00
69.00	06900	ELECTROCARDIOLOGY	1,023,101		1,023,101	0	1,023,101	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,195,301		1,195,301	0	1,195,301	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,525,587		2,525,587	0	2,525,587	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,175,796		4,175,796	0	4,175,796	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,616,890		28,616,890	0	28,616,890	73.00
74.00	07400	RENAL DIALYSIS	302,034		302,034	0	302,034	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,530,010		1,530,010	0	1,530,010	76.00
76.01	03190	CHEMOTHERAPY	6,222,405		6,222,405	0	6,222,405	76.01
76.02	03330	ENDOSCOPY	92,959		92,959	0	92,959	76.02
76.03	03950	WOUND CARE CENTER	1,383,099		1,383,099	0	1,383,099	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	428,895		428,895	0	428,895	90.00
91.00	09100	EMERGENCY	5,154,789		5,154,789	0	5,154,789	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,350,857		1,350,857		1,350,857	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,834,359		2,834,359	0	2,834,359	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	125,124,389	0	125,124,389	0	125,124,389	200.00
201.00		Less Observation Beds	1,350,857		1,350,857		1,350,857	201.00
202.00		Total (see instructions)	123,773,532	0	123,773,532	0	123,773,532	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/28/2021 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,561,104		27,561,104			30.00
31.00	03100	INTENSIVE CARE UNIT	11,304,427		11,304,427			31.00
41.00	04100	SUBPROVIDER - IRF	8,278,597		8,278,597			41.00
43.00	04300	NURSERY	2,821,564		2,821,564			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,067,732	68,964,483	96,032,215	0.106824	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,953,072	867,869	17,820,941	0.211185	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,045,211	22,321,413	25,366,624	0.217622	0.000000	54.00
54.01	03630	ULTRA SOUND	1,830,082	5,367,149	7,197,231	0.097492	0.000000	54.01
56.00	05600	RADIOISOTOPE	620,121	22,897,832	23,517,953	0.111419	0.000000	56.00
57.00	05700	CT SCAN	3,439,312	10,708,391	14,147,703	0.071286	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	745,872	2,699,778	3,445,650	0.273426	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	58,376	340,668	399,044	0.194355	0.000000	59.00
60.00	06000	LABORATORY	33,443,307	53,188,927	86,632,234	0.102144	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,784,051	4,893,460	13,677,511	0.162904	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,233,406	10,314,274	14,547,680	0.355552	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,536,540	1,871,330	5,407,870	0.245592	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	723,051	487,375	1,210,426	0.406240	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,770,500	11,868,517	14,639,017	0.069889	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	312,750	7,003,476	7,316,226	0.163377	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,326,447	8,716,052	17,042,499	0.148193	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,193,646	6,209,713	12,403,359	0.336667	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,217,920	53,214,133	72,432,053	0.395086	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,126,764	21,167	1,147,931	0.263112	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	427	5,005,622	5,006,049	0.305632	0.000000	76.00
76.01	03190	CHEMOTHERAPY	163,543	7,378,541	7,542,084	0.825025	0.000000	76.01
76.02	03330	ENDOSCOPY	91,400	264,343	355,743	0.261309	0.000000	76.02
76.03	03950	WOUND CARE CENTER	90,953	16,889,474	16,980,427	0.081453	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	15,411,511	55,770,971	71,182,482	0.072417	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,369,196	2,369,196	0.570175	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	9,920	12,111,319	12,121,239	0.233834	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	208,161,606	391,745,473	599,907,079			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	208,161,606	391,745,473	599,907,079			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/28/2021 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.106824	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.211185	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217622	54.00
54.01	03630	ULTRA SOUND	0.097492	54.01
56.00	05600	RADIOISOTOPE	0.111419	56.00
57.00	05700	CT SCAN	0.071286	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.273426	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.194355	59.00
60.00	06000	LABORATORY	0.102144	60.00
65.00	06500	RESPIRATORY THERAPY	0.162904	65.00
66.00	06600	PHYSICAL THERAPY	0.355552	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.245592	67.00
68.00	06800	SPEECH PATHOLOGY	0.406240	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069889	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.163377	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148193	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.336667	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.395086	73.00
74.00	07400	RENAL DIALYSIS	0.263112	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.305632	76.00
76.01	03190	CHEMOTHERAPY	0.825025	76.01
76.02	03330	ENDOSCOPY	0.261309	76.02
76.03	03950	WOUND CARE CENTER	0.081453	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.072417	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.570175	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.233834	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/28/2021 9:22 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,902,056		15,902,056	0	15,902,056	30.00
31.00	03100	INTENSIVE CARE UNIT	4,805,570		4,805,570	0	4,805,570	31.00
41.00	04100	SUBPROVIDER - IRF	3,537,438		3,537,438	0	3,537,438	41.00
43.00	04300	NURSERY	1,081,211		1,081,211	0	1,081,211	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,258,571		10,258,571	0	10,258,571	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,763,509		3,763,509	0	3,763,509	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,520,348		5,520,348	0	5,520,348	54.00
54.01	03630	ULTRA SOUND	701,669		701,669	0	701,669	54.01
56.00	05600	RADIOISOTOPE	2,620,345		2,620,345	0	2,620,345	56.00
57.00	05700	CT SCAN	1,008,540		1,008,540	0	1,008,540	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	942,130		942,130	0	942,130	58.00
59.00	05900	CARDIAC CATHETERIZATION	77,556		77,556	0	77,556	59.00
60.00	06000	LABORATORY	8,848,926		8,848,926	0	8,848,926	60.00
65.00	06500	RESPIRATORY THERAPY	2,228,128	0	2,228,128	0	2,228,128	65.00
66.00	06600	PHYSICAL THERAPY	5,172,456	0	5,172,456	0	5,172,456	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,328,130	0	1,328,130	0	1,328,130	67.00
68.00	06800	SPEECH PATHOLOGY	491,724	0	491,724	0	491,724	68.00
69.00	06900	ELECTROCARDIOLOGY	1,023,101		1,023,101	0	1,023,101	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,195,301		1,195,301	0	1,195,301	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,525,587		2,525,587	0	2,525,587	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,175,796		4,175,796	0	4,175,796	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,616,890		28,616,890	0	28,616,890	73.00
74.00	07400	RENAL DIALYSIS	302,034		302,034	0	302,034	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,530,010		1,530,010	0	1,530,010	76.00
76.01	03190	CHEMOTHERAPY	6,222,405		6,222,405	0	6,222,405	76.01
76.02	03330	ENDOSCOPY	92,959		92,959	0	92,959	76.02
76.03	03950	WOUND CARE CENTER	1,383,099		1,383,099	0	1,383,099	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	428,895		428,895	0	428,895	90.00
91.00	09100	EMERGENCY	5,154,789		5,154,789	0	5,154,789	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,350,857		1,350,857		1,350,857	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,834,359		2,834,359	0	2,834,359	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	125,124,389	0	125,124,389	0	125,124,389	200.00
201.00		Less Observation Beds	1,350,857		1,350,857		1,350,857	201.00
202.00		Total (see instructions)	123,773,532	0	123,773,532	0	123,773,532	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/28/2021 9:22 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,561,104		27,561,104			30.00
31.00	03100	INTENSIVE CARE UNIT	11,304,427		11,304,427			31.00
41.00	04100	SUBPROVIDER - IRF	8,278,597		8,278,597			41.00
43.00	04300	NURSERY	2,821,564		2,821,564			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,067,732	68,964,483	96,032,215	0.106824	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,953,072	867,869	17,820,941	0.211185	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,045,211	22,321,413	25,366,624	0.217622	0.000000	54.00
54.01	03630	ULTRA SOUND	1,830,082	5,367,149	7,197,231	0.097492	0.000000	54.01
56.00	05600	RADIOISOTOPE	620,121	22,897,832	23,517,953	0.111419	0.000000	56.00
57.00	05700	CT SCAN	3,439,312	10,708,391	14,147,703	0.071286	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	745,872	2,699,778	3,445,650	0.273426	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	58,376	340,668	399,044	0.194355	0.000000	59.00
60.00	06000	LABORATORY	33,443,307	53,188,927	86,632,234	0.102144	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,784,051	4,893,460	13,677,511	0.162904	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,233,406	10,314,274	14,547,680	0.355552	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,536,540	1,871,330	5,407,870	0.245592	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	723,051	487,375	1,210,426	0.406240	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,770,500	11,868,517	14,639,017	0.069889	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	312,750	7,003,476	7,316,226	0.163377	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,326,447	8,716,052	17,042,499	0.148193	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,193,646	6,209,713	12,403,359	0.336667	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,217,920	53,214,133	72,432,053	0.395086	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,126,764	21,167	1,147,931	0.263112	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	427	5,005,622	5,006,049	0.305632	0.000000	76.00
76.01	03190	CHEMOTHERAPY	163,543	7,378,541	7,542,084	0.825025	0.000000	76.01
76.02	03330	ENDOSCOPY	91,400	264,343	355,743	0.261309	0.000000	76.02
76.03	03950	WOUND CARE CENTER	90,953	16,889,474	16,980,427	0.081453	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	15,411,511	55,770,971	71,182,482	0.072417	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,369,196	2,369,196	0.570175	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	9,920	12,111,319	12,121,239	0.233834	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	208,161,606	391,745,473	599,907,079			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	208,161,606	391,745,473	599,907,079			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/28/2021 9:22 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630	ULTRA SOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
76.01	03190	CHEMOTHERAPY	0.000000		76.01
76.02	03330	ENDOSCOPY	0.000000		76.02
76.03	03950	WOUND CARE CENTER	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part I Date/Time Prepared: 11/28/2021 9:22 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	988,540	0	988,540	14,962	66.07	30.00
31.00	INTENSIVE CARE UNIT	282,797		282,797	2,624	107.77	31.00
41.00	SUBPROVIDER - IRF	283,232	0	283,232	4,185	67.68	41.00
43.00	NURSERY	75,516		75,516	1,430	52.81	43.00
200.00	Total (lines 30 through 199)	1,630,085		1,630,085	23,201		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	6,518	430,644		30.00
31.00	INTENSIVE CARE UNIT	883	95,161		31.00
41.00	SUBPROVIDER - IRF	2,368	160,266		41.00
43.00	NURSERY	0	0		43.00
200.00	Total (lines 30 through 199)	9,769	686,071		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part II Date/Time Prepared: 11/28/2021 9:22 am

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		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,117,900	96,032,215	0.011641	11,783,190	137,168	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	232,785	17,820,941	0.013062	120,602	1,575	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,229,102	25,366,624	0.048454	1,200,473	58,168	54.00
54.01	03630	ULTRA SOUND	122,681	7,197,231	0.017046	622,779	10,616	54.01
56.00	05600	RADIOISOTOPE	626,913	23,517,953	0.026657	215,535	5,746	56.00
57.00	05700	CT SCAN	25,102	14,147,703	0.001774	1,325,730	2,352	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	285,945	3,445,650	0.082987	256,500	21,286	58.00
59.00	05900	CARDIAC CATHETERIZATION	22,332	399,044	0.055964	49,761	2,785	59.00
60.00	06000	LABORATORY	290,324	86,632,234	0.003351	12,333,719	41,330	60.00
65.00	06500	RESPIRATORY THERAPY	105,972	13,677,511	0.007748	2,975,860	23,057	65.00
66.00	06600	PHYSICAL THERAPY	236,859	14,547,680	0.016282	979,597	15,950	66.00
67.00	06700	OCCUPATIONAL THERAPY	75,613	5,407,870	0.013982	786,129	10,992	67.00
68.00	06800	SPEECH PATHOLOGY	26,719	1,210,426	0.022074	186,017	4,106	68.00
69.00	06900	ELECTROCARDIOLOGY	229,583	14,639,017	0.015683	1,543,147	24,201	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	81,501	7,316,226	0.011140	189,697	2,113	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	207,487	17,042,499	0.012175	3,300,268	40,181	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,316	12,403,359	0.007120	3,079,477	21,926	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	689,064	72,432,053	0.009513	6,812,355	64,806	73.00
74.00	07400	RENAL DIALYSIS	6,537	1,147,931	0.005695	430,024	2,449	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	107,503	5,006,049	0.021475	0	0	76.00
76.01	03190	CHEMOTHERAPY	548,366	7,542,084	0.072707	8,948	651	76.01
76.02	03330	ENDOSCOPY	13,319	355,743	0.037440	37,702	1,412	76.02
76.03	03950	WOUND CARE CENTER	42,873	16,980,427	0.002525	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,552	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	448,163	71,182,482	0.006296	4,489,157	28,264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	83,975	2,369,196	0.035445	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50 through 199)	6,955,486	537,820,148		52,726,667	521,134	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part III Date/Time Prepared: 11/28/2021 9:22 am

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		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	14,962	0.00	6,518	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,624	0.00	883	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	4,185	0.00	2,368	41.00
43.00	04300	NURSERY		0	1,430	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	23,201		9,769	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
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: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/28/2021 9:22 am

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	121,824	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	34,561	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	112,933	56.00
57.00	05700	CT SCAN	0	0	0	0	67,937	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	16,546	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	353,801	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/28/2021 9:22 am

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		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	96,032,215	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	17,820,941	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	121,824	121,824	25,366,624	0.004803	54.00
54.01	03630	ULTRA SOUND	0	34,561	34,561	7,197,231	0.004802	54.01
56.00	05600	RADIOISOTOPE	0	112,933	112,933	23,517,953	0.004802	56.00
57.00	05700	CT SCAN	0	67,937	67,937	14,147,703	0.004802	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	16,546	16,546	3,445,650	0.004802	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	399,044	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	86,632,234	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,677,511	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	14,547,680	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,407,870	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,210,426	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,639,017	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,316,226	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	17,042,499	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,403,359	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	72,432,053	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,147,931	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	5,006,049	0.000000	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	7,542,084	0.000000	76.01
76.02	03330	ENDOSCOPY	0	0	0	355,743	0.000000	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	16,980,427	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	71,182,482	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,369,196	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	353,801	353,801	537,820,148		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/28/2021 9:22 am

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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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	11,783,190	0	19,069,854	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	120,602	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.004803	1,200,473	5,766	5,338,007	25,638	54.00
54.01	03630	ULTRA SOUND	0.004802	622,779	2,991	1,316,065	6,320	54.01
56.00	05600	RADIOISOTOPE	0.004802	215,535	1,035	8,211,140	39,430	56.00
57.00	05700	CT SCAN	0.004802	1,325,730	6,366	2,892,606	13,890	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.004802	256,500	1,232	737,118	3,540	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	49,761	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	12,333,719	0	7,101,689	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,975,860	0	98,475	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	979,597	0	48,782	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	786,129	0	15,256	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	186,017	0	12,720	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,543,147	0	5,743,501	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	189,697	0	188,940	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	3,300,268	0	1,899,693	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,079,477	0	2,357,755	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	6,812,355	0	20,132,998	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	430,024	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.000000	8,948	0	3,089,494	0	76.01
76.02	03330	ENDOSCOPY	0.000000	37,702	0	75,434	0	76.02
76.03	03950	WOUND CARE CENTER	0.000000	0	0	5,462,310	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	4,489,157	0	11,518,059	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	1,729,356	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Total (lines 50 through 199)		52,726,667	17,390	97,039,252	88,818	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/28/2021 9:22 am

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		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.106824	19,069,854	0	0	2,037,118	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.211185	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217622	5,338,007	0	0	1,161,668	54.00
54.01	03630	ULTRA SOUND	0.097492	1,316,065	0	0	128,306	54.01
56.00	05600	RADIOISOTOPE	0.111419	8,211,140	0	0	914,877	56.00
57.00	05700	CT SCAN	0.071286	2,892,606	0	0	206,202	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.273426	737,118	0	0	201,547	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.194355	0	0	0	0	59.00
60.00	06000	LABORATORY	0.102144	7,101,689	0	0	725,395	60.00
65.00	06500	RESPIRATORY THERAPY	0.162904	98,475	0	0	16,042	65.00
66.00	06600	PHYSICAL THERAPY	0.355552	48,782	0	0	17,345	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.245592	15,256	0	0	3,747	67.00
68.00	06800	SPEECH PATHOLOGY	0.406240	12,720	0	0	5,167	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069889	5,743,501	0	0	401,408	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.163377	188,940	0	0	30,868	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148193	1,899,693	0	0	281,521	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.336667	2,357,755	0	0	793,778	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.395086	20,132,998	0	12,542	7,954,266	73.00
74.00	07400	RENAL DIALYSIS	0.263112	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.305632	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.825025	3,089,494	0	0	2,548,910	76.01
76.02	03330	ENDOSCOPY	0.261309	75,434	0	0	19,712	76.02
76.03	03950	WOUND CARE CENTER	0.081453	5,462,310	0	0	444,922	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.072417	11,518,059	0	0	834,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.570175	1,729,356	0	0	986,036	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.233834		0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		97,039,252	0	12,542	19,712,938	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		97,039,252	0	12,542	19,712,938	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/28/2021 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,955		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
76.01	03190	CHEMOTHERAPY	0	0		76.01
76.02	03330	ENDOSCOPY	0	0		76.02
76.03	03950	WOUND CARE CENTER	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	0	4,955		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	4,955		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part II Date/Time Prepared: 11/28/2021 9:22 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,117,900	96,032,215	0.011641	142,898	1,663	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	232,785	17,820,941	0.013062	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,229,102	25,366,624	0.048454	57,168	2,770	54.00
54.01	03630	ULTRA SOUND	122,681	7,197,231	0.017046	13,501	230	54.01
56.00	05600	RADIOISOTOPE	626,913	23,517,953	0.026657	0	0	56.00
57.00	05700	CT SCAN	25,102	14,147,703	0.001774	23,800	42	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	285,945	3,445,650	0.082987	2,850	237	58.00
59.00	05900	CARDIAC CATHETERIZATION	22,332	399,044	0.055964	0	0	59.00
60.00	06000	LABORATORY	290,324	86,632,234	0.003351	1,129,429	3,785	60.00
65.00	06500	RESPIRATORY THERAPY	105,972	13,677,511	0.007748	168,591	1,306	65.00
66.00	06600	PHYSICAL THERAPY	236,859	14,547,680	0.016282	1,161,767	18,916	66.00
67.00	06700	OCCUPATIONAL THERAPY	75,613	5,407,870	0.013982	1,024,626	14,326	67.00
68.00	06800	SPEECH PATHOLOGY	26,719	1,210,426	0.022074	159,320	3,517	68.00
69.00	06900	ELECTROCARDIOLOGY	229,583	14,639,017	0.015683	80,492	1,262	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	81,501	7,316,226	0.011140	2,517	28	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	207,487	17,042,499	0.012175	198,188	2,413	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,316	12,403,359	0.007120	5,474	39	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	689,064	72,432,053	0.009513	560,832	5,335	73.00
74.00	07400	RENAL DIALYSIS	6,537	1,147,931	0.005695	111,183	633	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	107,503	5,006,049	0.021475	0	0	76.00
76.01	03190	CHEMOTHERAPY	548,366	7,542,084	0.072707	0	0	76.01
76.02	03330	ENDOSCOPY	13,319	355,743	0.037440	0	0	76.02
76.03	03950	WOUND CARE CENTER	42,873	16,980,427	0.002525	3,228	8	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,552	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	448,163	71,182,482	0.006296	9,162	58	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,369,196	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50 through 199)	6,871,511	537,820,148		4,855,026	56,568	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/28/2021 9:22 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	121,824	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	34,561	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	112,933	56.00
57.00	05700	CT SCAN	0	0	0	0	67,937	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	16,546	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	353,801	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/28/2021 9:22 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	96,032,215	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	17,820,941	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	121,824	121,824	25,366,624	0.004803	54.00
54.01	03630	ULTRA SOUND	0	34,561	34,561	7,197,231	0.004802	54.01
56.00	05600	RADIOISOTOPE	0	112,933	112,933	23,517,953	0.004802	56.00
57.00	05700	CT SCAN	0	67,937	67,937	14,147,703	0.004802	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	16,546	16,546	3,445,650	0.004802	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	399,044	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	86,632,234	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,677,511	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	14,547,680	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,407,870	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,210,426	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,639,017	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,316,226	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	17,042,499	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,403,359	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	72,432,053	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,147,931	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	5,006,049	0.000000	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	7,542,084	0.000000	76.01
76.02	03330	ENDOSCOPY	0	0	0	355,743	0.000000	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	16,980,427	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	71,182,482	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,369,196	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	353,801	353,801	537,820,148		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/28/2021 9:22 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	142,898	0	3,308	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.004803	57,168	275	635	3	54.00
54.01	03630	ULTRA SOUND	0.004802	13,501	65	0	0	54.01
56.00	05600	RADIOISOTOPE	0.004802	0	0	0	0	56.00
57.00	05700	CT SCAN	0.004802	23,800	114	1,700	8	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.004802	2,850	14	950	5	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,129,429	0	12,215	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	168,591	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,161,767	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,024,626	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	159,320	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	80,492	0	930	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	2,517	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	198,188	0	208	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,474	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	560,832	0	3,009	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	111,183	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.000000	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0.000000	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.000000	3,228	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	9,162	0	16,951	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Total (lines 50 through 199)		4,855,026	468	39,906	16	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/28/2021 9:22 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.106824	3,308	0	0	353	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.211185	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217622	635	0	0	138	54.00
54.01	03630	ULTRA SOUND	0.097492	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.111419	0	0	0	0	56.00
57.00	05700	CT SCAN	0.071286	1,700	0	0	121	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.273426	950	0	0	260	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.194355	0	0	0	0	59.00
60.00	06000	LABORATORY	0.102144	12,215	0	0	1,248	60.00
65.00	06500	RESPIRATORY THERAPY	0.162904	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.355552	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.245592	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.406240	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069889	930	0	0	65	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.163377	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148193	208	0	0	31	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.336667	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.395086	3,009	0	0	1,189	73.00
74.00	07400	RENAL DIALYSIS	0.263112	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.305632	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.825025	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0.261309	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.081453	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.072417	16,951	0	0	1,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.570175	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.233834		0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		39,906	0	0	4,633	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		39,906	0	0	4,633	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V | Date/Time Prepared: 11/28/2021 9:22 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
76.01	03190	CHEMOTHERAPY	0	0		76.01
76.02	03330	ENDOSCOPY	0	0		76.02
76.03	03950	WOUND CARE CENTER	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/28/2021 9:22 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.106824	0	473,174	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.211185	0	22,742	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217622	0	270,297	0	0	54.00
54.01	03630	ULTRA SOUND	0.097492	0	67,243	0	0	54.01
56.00	05600	RADIOISOTOPE	0.111419	0	0	0	0	56.00
57.00	05700	CT SCAN	0.071286	0	157,440	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.273426	0	30,441	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.194355	0	16,962	0	0	59.00
60.00	06000	LABORATORY	0.102144	0	937,850	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.162904	0	62,966	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.355552	0	69,332	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.245592	0	28,173	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.406240	0	6,306	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069889	0	73,779	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.163377	0	65,261	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148193	0	64,881	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.336667	0	46,225	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.395086	0	205,513	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.263112	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.305632	0	30,729	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.825025	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0.261309	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.081453	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.072417	0	1,626,606	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.570175	0	37,765	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.233834	0	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	4,293,685	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	4,293,685	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/28/2021 9:22 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	50,546	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,803	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,823	0		54.00
54.01	03630	ULTRA SOUND	6,556	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	11,223	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,323	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	3,297	0		59.00
60.00	06000	LABORATORY	95,796	0		60.00
65.00	06500	RESPIRATORY THERAPY	10,257	0		65.00
66.00	06600	PHYSICAL THERAPY	24,651	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	6,919	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,562	0		68.00
69.00	06900	ELECTROCARDIOLOGY	5,156	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,662	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,615	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,562	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	81,195	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	9,392	0		76.00
76.01	03190	CHEMOTHERAPY	0	0		76.01
76.02	03330	ENDOSCOPY	0	0		76.02
76.03	03950	WOUND CARE CENTER	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	117,794	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	21,533	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	554,665	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	554,665	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/28/2021 9:22 am
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,962	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,962	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)	13,691	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)	6,518	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	15,902,056	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)	15,902,056	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	15,902,056	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,062.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,927,526	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)	6,927,526	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/28/2021 9:22 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,805,570	2,624	1,831.39	883	1,617,117	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)	8,977,625	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	17,522,268	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)	525,805	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	538,524	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,064,329	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	16,457,939	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)	1,271	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,062.83	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,350,857	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/28/2021 9:22 am
	Title XVIII	Hospital	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	988,540	15,902,056	0.062164	1,350,857	83,975	90.00
91.00	Nursing School cost	0	15,902,056	0.000000	1,350,857	0	91.00
92.00	Allied health cost	0	15,902,056	0.000000	1,350,857	0	92.00
93.00	All other Medical Education	0	15,902,056	0.000000	1,350,857	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/28/2021 9:22 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,185	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,185	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)	4,185	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,368	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,537,438	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)	3,537,438	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,537,438	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	845.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,001,599	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,001,599	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/28/2021 9:22 am

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	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)	1,192,764	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,194,363	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)	160,266	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	57,036	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	217,302	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,977,061	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: 15-0010 Component CCN: 15-T010	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/28/2021 9:22 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	283,232	3,537,438	0.080067	0	0	90.00
91.00	Nursing School cost	0	3,537,438	0.000000	0	0	91.00
92.00	Allied health cost	0	3,537,438	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,537,438	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/28/2021 9:22 am
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,962	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,962	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)	13,691	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)	272	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)	580	14.00
15.00	Total nursery days (title V or XIX only)	1,430	15.00
16.00	Nursery days (title V or XIX only)	134	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	15,902,056	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)	15,902,056	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	15,902,056	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,062.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	289,090	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)	289,090	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/28/2021 9:22 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,081,211	1,430	756.09	134	101,316	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,805,570	2,624	1,831.39	174	318,662	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)	757,957	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,467,025	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)	1,271	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,062.83	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,350,857	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/28/2021 9:22 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	988,540	15,902,056	0.062164	1,350,857	83,975	90.00
91.00	Nursing School cost	0	15,902,056	0.000000	1,350,857	0	91.00
92.00	Allied health cost	0	15,902,056	0.000000	1,350,857	0	92.00
93.00	All other Medical Education	0	15,902,056	0.000000	1,350,857	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 11/28/2021 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		11,297,441		30.00
31.00	03100	INTENSIVE CARE UNIT		3,993,279		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.106824	11,783,190	1,258,727	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.211185	120,602	25,469	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217622	1,200,473	261,249	54.00
54.01	03630	ULTRA SOUND	0.097492	622,779	60,716	54.01
56.00	05600	RADIOISOTOPE	0.111419	215,535	24,015	56.00
57.00	05700	CT SCAN	0.071286	1,325,730	94,506	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.273426	256,500	70,134	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.194355	49,761	9,671	59.00
60.00	06000	LABORATORY	0.102144	12,333,719	1,259,815	60.00
65.00	06500	RESPIRATORY THERAPY	0.162904	2,975,860	484,779	65.00
66.00	06600	PHYSICAL THERAPY	0.355552	979,597	348,298	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.245592	786,129	193,067	67.00
68.00	06800	SPEECH PATHOLOGY	0.406240	186,017	75,568	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069889	1,543,147	107,849	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.163377	189,697	30,992	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148193	3,300,268	489,077	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.336667	3,079,477	1,036,758	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.395086	6,812,355	2,691,466	73.00
74.00	07400	RENAL DIALYSIS	0.263112	430,024	113,144	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.305632	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.825025	8,948	7,382	76.01
76.02	03330	ENDOSCOPY	0.261309	37,702	9,852	76.02
76.03	03950	WOUND CARE CENTER	0.081453	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.072417	4,489,157	325,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.570175	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		52,726,667	8,977,625	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)		52,726,667		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 11/28/2021 9:22 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	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF		4,669,168		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.106824	142,898	15,265	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.211185	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217622	57,168	12,441	54.00
54.01	03630	ULTRA SOUND	0.097492	13,501	1,316	54.01
56.00	05600	RADIOISOTOPE	0.111419	0	0	56.00
57.00	05700	CT SCAN	0.071286	23,800	1,697	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.273426	2,850	779	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.194355	0	0	59.00
60.00	06000	LABORATORY	0.102144	1,129,429	115,364	60.00
65.00	06500	RESPIRATORY THERAPY	0.162904	168,591	27,464	65.00
66.00	06600	PHYSICAL THERAPY	0.355552	1,161,767	413,069	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.245592	1,024,626	251,640	67.00
68.00	06800	SPEECH PATHOLOGY	0.406240	159,320	64,722	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069889	80,492	5,626	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.163377	2,517	411	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148193	198,188	29,370	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.336667	5,474	1,843	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.395086	560,832	221,577	73.00
74.00	07400	RENAL DIALYSIS	0.263112	111,183	29,254	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.305632	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.825025	0	0	76.01
76.02	03330	ENDOSCOPY	0.261309	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.081453	3,228	263	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.072417	9,162	663	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.570175	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,855,026	1,192,764	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,855,026		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 11/28/2021 9:22 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		811,063		30.00
31.00	03100	INTENSIVE CARE UNIT		455,751		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		138,533		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.106824	762,938	81,500	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.211185	554,131	117,024	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217622	82,974	18,057	54.00
54.01	03630	ULTRA SOUND	0.097492	55,839	5,444	54.01
56.00	05600	RADIOISOTOPE	0.111419	0	0	56.00
57.00	05700	CT SCAN	0.071286	113,220	8,071	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.273426	21,626	5,913	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.194355	0	0	59.00
60.00	06000	LABORATORY	0.102144	1,057,823	108,050	60.00
65.00	06500	RESPIRATORY THERAPY	0.162904	238,535	38,858	65.00
66.00	06600	PHYSICAL THERAPY	0.355552	9,884	3,514	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.245592	4,016	986	67.00
68.00	06800	SPEECH PATHOLOGY	0.406240	88	36	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069889	71,872	5,023	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.163377	13,885	2,268	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148193	168,238	24,932	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.336667	125,145	42,132	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.395086	584,348	230,868	73.00
74.00	07400	RENAL DIALYSIS	0.263112	43,622	11,477	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.305632	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.825025	3,302	2,724	76.01
76.02	03330	ENDOSCOPY	0.261309	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.081453	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.072417	705,358	51,080	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.570175	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,616,844	757,957	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,616,844		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 11/28/2021 9:22 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	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF		25,872		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.106824	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.211185	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217622	1,862	405	54.00
54.01	03630	ULTRA SOUND	0.097492	0	0	54.01
56.00	05600	RADIOISOTOPE	0.111419	0	0	56.00
57.00	05700	CT SCAN	0.071286	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.273426	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.194355	0	0	59.00
60.00	06000	LABORATORY	0.102144	62,317	6,365	60.00
65.00	06500	RESPIRATORY THERAPY	0.162904	4,497	733	65.00
66.00	06600	PHYSICAL THERAPY	0.355552	54,335	19,319	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.245592	22,079	5,422	67.00
68.00	06800	SPEECH PATHOLOGY	0.406240	4,942	2,008	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069889	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.163377	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148193	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.336667	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.395086	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.263112	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.305632	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.825025	0	0	76.01
76.02	03330	ENDOSCOPY	0.261309	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.081453	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.072417	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.570175	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		150,032	34,252	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)		150,032		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/28/2021 9:22 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	3,269,534	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	10,446,829	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)	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	185,272	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	115.52	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	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	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	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)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.69	30.00
31.00	Percentage of Medicaid patient days (see instructions)	21.11	31.00
32.00	Sum of lines 30 and 31	24.80	32.00
33.00	Allowable disproportionate share percentage (see instructions)	9.68	33.00
34.00	Disproportionate share adjustment (see instructions)	331,936	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E Part A Date/Time Prepared: 11/28/2021 9:22 am

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	8,350,599,096	8,290,014,521	35.00
35.01	Factor 3 (see instructions)	0.000168128	0.000232246	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,403,970	1,925,321	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	352,910	1,440,034	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,792,944		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	16,026,515		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		16,026,515	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,107,057	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).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		30,126	53.00
54.00	Special add-on payments for new technologies		221,286	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		17,390	58.00
59.00	Total (sum of amounts on lines 49 through 58)		17,402,374	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		17,402,374	61.00
62.00	Deductibles billed to program beneficiaries		1,466,288	62.00
63.00	Coinsurance billed to program beneficiaries		11,654	63.00
64.00	Allowable bad debts (see instructions)		71,246	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		46,310	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		23,196	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		15,970,742	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-6,742	70.93
70.94	HRR adjustment amount (see instructions)		-9,809	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/28/2021 9:22 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)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		15,954,191	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		15,780,357	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)		173,834	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		276,022	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/28/2021 9:22 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	3,269,534	0	3,269,534		3,269,534	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,446,829	0		10,446,829	10,446,829	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	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	185,272	0		185,272	185,272	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
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	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0968	0.0968	0.0968	0.0968		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	331,936	0	79,123	252,813	331,936	11.00
11.01	Uncompensated care payments	36.00	1,792,944	0	352,910	1,440,034	1,792,944	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	16,026,515	0	3,701,567	12,324,948	16,026,515	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	16,026,515	0	3,701,567	12,324,948	16,026,515	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,107,057	0	269,163	837,894	1,107,057	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/28/2021 9:22 am

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		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	221,286	0	0	221,286	221,286	17.00
17.01	Net organ aquisition 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	3,970,730	13,384,128	17,354,858	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	1,042,141	0	255,980	786,161	1,042,141	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	11,246	0	0	11,246	11,246	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	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0515	0.0515	0.0515	0.0515		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	53,670	0	13,183	40,487	53,670	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,107,057	0	269,163	837,894	1,107,057	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: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/28/2021 9:22 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 (cols. 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	3,269,534	3,269,534		3,269,534	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,446,829		10,446,829	10,446,829	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	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	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	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	185,272		185,272	185,272	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0968	0.0968	0.0968		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	331,936	79,123	252,813	331,936	11.00
11.01	Uncompensated care payments	36.00	1,792,944	352,910	1,440,034	1,792,944	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	16,026,515	3,701,567	12,324,948	16,026,515	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	16,026,515	3,701,567	12,324,948	16,026,515	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,107,057	269,163	837,894	1,107,057	16.00
17.00	Special add-on payments for new technologies	54.00	221,286	0	221,286	221,286	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	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			3,970,730	13,384,128	17,354,858	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/28/2021 9:22 am

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		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	1,042,141	255,980	786,161	1,042,141	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	11,246	0	11,246	11,246	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	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0515	0.0515	0.0515		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	53,670	13,183	40,487	53,670	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,107,057	269,163	837,894	1,107,057	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	-6,742	1,872	-8,614	-6,742	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	-9,809	-9,809	0	-9,809	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		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/28/2021 9:22 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,955	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	19,624,120	2.00
3.00	OPPS payments	16,850,439	3.00
4.00	Outlier payment (see instructions)	123,495	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	88,818	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,955	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	12,542	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)	12,542	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	12,542	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	7,587	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)	4,955	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)	17,062,752	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
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)	3,024,632	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)	14,043,075	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)	14,043,075	30.00
31.00	Primary payer payments	274	31.00
32.00	Subtotal (line 30 minus line 31)	14,042,801	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	188,691	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	122,649	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	91,095	36.00
37.00	Subtotal (see instructions)	14,165,450	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-26	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)	14,165,476	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	14,323,574	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-158,098	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/28/2021 9:22 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4,617	2.00
3.00	OPPS payments	2,171	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	16	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	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)	2,187	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
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)	434	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)	1,753	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)	1,753	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,753	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	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)	1,753	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,753	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	1,737	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	16	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-1 Part I Date/Time Prepared: 11/28/2021 9:22 am

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		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		15,743,757		14,276,174	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	01/06/2021	36,600	01/06/2021	47,400	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)		36,600		47,400	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)		15,780,357		14,323,574	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		173,834		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		158,098	6.02
7.00	Total Medicare program liability (see instructions)		15,954,191		14,165,476	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: 15-0010 Component CCN: 15-T010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-1 Part I Date/Time Prepared: 11/28/2021 9:22 am

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		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		4,134,202		1,737	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)		4,134,202		1,737	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		16	6.01
6.02	SETTLEMENT TO PROGRAM		7,182		0	6.02
7.00	Total Medicare program liability (see instructions)		4,127,020		1,753	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: 15-0010	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part II Date/Time Prepared: 11/28/2021 9:22 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part III Date/Time Prepared: 11/28/2021 9:22 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	4,007,603	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	111,812	3.00
4.00	Outlier Payments	39,342	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)	11.465753	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)	4,158,757	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)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	4,158,757	17.00
18.00	Primary payer payments	5,714	18.00
19.00	Subtotal (line 17 less line 18).	4,153,043	19.00
20.00	Deductibles	27,208	20.00
21.00	Subtotal (line 19 minus line 20)	4,125,835	21.00
22.00	Coinsurance	1,484	22.00
23.00	Subtotal (line 21 minus line 22)	4,124,351	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	3,386	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	2,201	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)	4,126,552	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)	468	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
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	4,127,020	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	4,134,202	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)	-7,182	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	39,342	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/28/2021 9:22 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	1,467,025		1.00
2.00	Medical and other services		554,665	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	1,467,025	554,665	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)	1,467,025	554,665	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	4,616,844	4,293,685	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)	4,616,844	4,293,685	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	4,616,844	4,293,685	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	3,149,819	3,739,020	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)	1,467,025	554,665	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	1,467,025	554,665	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,467,025	554,665	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	1,467,025	554,665	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	1,467,025	554,665	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)	1,467,025	554,665	40.00
41.00	Interim payments	1,467,025	554,665	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/28/2021 9:22 am
	Title XIX	Subprovider - IRF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	150,032	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)	150,032	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	150,032	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	150,032	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-4 | Date/Time Prepared: 11/28/2021 9:22 am

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	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	0.00		17.00
18.00	Per resident amount	0.00	0.00		18.00
19.00	Approved amount for resident costs	0	0	0	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)			0	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)	9,769	4,875		26.00
27.00	Total Inpatient Days (see instructions)	22,027	22,027		27.00
28.00	Ratio of inpatient days to total inpatient days	0.443501	0.221319		28.00
29.00	Program direct GME amount	0	0	0	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	0	30.00
31.00	Net Program direct GME amount			0	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0010	Period: From 07/01/2020 To 06/30/2021	Worksheet E-4 Date/Time Prepared: 11/28/2021 9:22 am
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	1,147,931	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	20,716,631	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	5,714	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	20,710,917	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	19,722,526	42.00
43.00	Primary payer payments (see instructions)	274	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	19,722,252	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	40,433,169	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.512226	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.487774	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	0	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	0	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	0	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G | Date/Time Prepared: 11/28/2021 9:22 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,275	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	20,004,053	0	0	0	4.00
5.00	Other receivable	2,694,411	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,980,006	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	17,698	0	0	0	9.00
10.00	Due from other funds	63,817	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	24,761,260	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	671,919	0	0	0	12.00
13.00	Land improvements	1,934,722	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	82,025,097	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	653,423	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	21,083,741	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	1,205,669	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	52,237,120	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	-122,037,631	0	0	0	28.00
29.00	Minor equipment-nondepreciable	245,236	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	38,019,296	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	175,068	0	0	0	31.00
32.00	Deposits on leases	1,291,042	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	36,132	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,502,242	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	64,282,798	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,000,270	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,946,648	0	0	0	38.00
39.00	Payroll taxes payable	564,255	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	15,354,280	0	0	0	43.00
44.00	Other current liabilities	6,741,403	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	28,606,856	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,778,918	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,778,918	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	32,385,774	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	31,897,024				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	31,897,024	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	64,282,798	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G-1 | Date/Time Prepared: 11/28/2021 9:22 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		1,735,540		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		33,174,878				2.00
3.00	Total (sum of line 1 and line 2)		34,910,418		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		34,910,418		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		34,910,418		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: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/28/2021 9:22 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	30,382,668		30,382,668	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	8,278,597		8,278,597	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)	38,661,265		38,661,265	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	11,304,427		11,304,427	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)	11,304,427		11,304,427	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	49,965,692		49,965,692	17.00
18.00	Ancillary services	142,774,482	321,493,987	464,268,469	18.00
19.00	Outpatient services	15,411,511	58,140,167	73,551,678	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	9,920	12,111,319	12,121,239	27.00
27.01	CLINIC OF HOPE	492,221	991,949	1,484,170	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	208,653,826	392,737,422	601,391,248	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		140,639,786		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)		140,639,786		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G-3 | Date/Time Prepared: 11/28/2021 9:22 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	601,391,248	1.00
2.00	Less contractual allowances and discounts on patients' accounts	432,323,716	2.00
3.00	Net patient revenues (line 1 minus line 2)	169,067,532	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	140,639,786	4.00
5.00	Net income from service to patients (line 3 minus line 4)	28,427,746	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	338,109	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	744	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	134,921	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISCELLANEOUS REVENUE	42,583	24.00
24.01	CONTRACT SERVICES REVENUE	0	24.01
24.02	OTHER MISCELLANEOUS REVENUE	0	24.02
24.03	IC RENTAL INCOME	125,343	24.03
24.04	FOUNDATION IC TRNSF	183,690	24.04
24.05	GAIN ON SALE DISPOSAL PPE	8,140	24.05
24.06	PATIENT INTEREST INCOME	-42,550	24.06
24.07	UNCLAIMED PROPERTY EXEMPTIONS	68	24.07
24.08	MEDICAL AFFAIRS ADMIN - ADMINISTRATI	182,713	24.08
24.09	VENDING REVENUE	197	24.09
24.10	SEMINARSTUITION REVENUE	23,747	24.10
24.11	IIUE INCOME LOSS	127,755	24.11
24.12	IC SHARED SAV REV ACO	145,535	24.12
24.13	OTHER (SPECIFY)	0	24.13
24.14	NETASSETSRELFROMRESTRCAPITAL	-146,425	24.14
24.15	STATE SPONS PRJ REV	398,392	24.15
24.16	OTHER (SPECIFY)	0	24.16
24.17	OTHER (SPECIFY)	0	24.17
24.18	OTHER (SPECIFY)	0	24.18
24.19	OTHER (SPECIFY)	0	24.19
24.20	MEALS ON WHEELS REVENUE	74,733	24.20
24.50	COVID-19 PHE Funding	3,149,437	24.50
25.00	Total other income (sum of lines 6-24)	4,747,132	25.00
26.00	Total (line 5 plus line 25)	33,174,878	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)	33,174,878	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0010	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Prepared: 11/28/2021 9:22 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,042,141	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	11,246	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)	49.59	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	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)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	3.69	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	21.11	8.00
9.00	Sum of lines 7 and 8	24.80	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.15	10.00
11.00	Disproportionate share adjustment (see instructions)	53,670	11.00
12.00	Total prospective capital payments (see instructions)	1,107,057	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00