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: 15-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/18/2021 5:26 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/18/2021 Time: 5:26 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ASCENSION ST. VINCENT RANDOLPH (15-1301) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) CHRIS HONS
Officer or Administrator of Provider(s)

VP OF FINANCE
Title

11/18/2021 05:26:46 PM
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-59,876	-780,744	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	-3,065	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-62,941	-780,744	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: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2021 5:26 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 473 GREENVILLE AVE.	PO Box:			1.00
2.00	City: WINCHESTER	State: IN	Zip Code: 47934	County: RANDOLPH	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 RANDOLPH	151301	99915	1	01/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ASCENSION ST. VINCENT RANDOLPH SWING	15Z301	99915		09/01/1999	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/18/2021 5:26 pm

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I | Date/Time Prepared: 11/18/2021 5:26 pm

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/18/2021 5:26 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	141,866	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H046	140.00

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part II Date/Time Prepared: 11/18/2021 5:26 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/05/2021	Y	10/05/2021	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: 15-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/18/2021 5:26 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL	HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ASCENSION		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3232	JILL.HILL1@ASCENSION.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/18/2021 5:26 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I | Date/Time Prepared: 11/18/2021 5:26 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	27,096.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	27,096.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	27,096.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I Date/Time Prepared: 11/18/2021 5:26 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	235	30	1,129			1.00
2.00	HMO and other (see instructions)	133	427				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	27	0	58			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)	262	30	1,187			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		46	434			13.00
14.00	Total (see instructions)	262	76	1,621	0.00	61.56	14.00
15.00	CAH visits	10,595	818	42,140			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	61.56	27.00
28.00	Observation Bed Days		0	181			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			13			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	2	108			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: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I Date/Time Prepared: 11/18/2021 5:26 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	61	15	427	1.00
2.00	HMO and other (see instructions)			31	158		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	61	15	427	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-10 | Date/Time Prepared: 11/18/2021 5:26 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.225743	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,615,623	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	26,808,869	6.00
7.00	Medicaid cost (line 1 times line 6)	6,051,915	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)	1,436,292	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)	1,436,292	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)	2,549,686	694,190	3,243,876	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	575,574	694,190	1,269,764	21.00
22.00	Payments received from patients for amounts previously written off as charity care	366,836	20,142	386,978	22.00
23.00	Cost of charity care (line 21 minus line 22)	208,738	674,048	882,786	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)	4,201,128	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	358,331	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	551,279	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,649,849	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,016,876	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,899,662	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,335,954	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A | Date/Time Prepared: 11/18/2021 5:26 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		689,500	689,500	0	689,500	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		680,578	680,578	0	680,578	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	60,063	1,324,955	1,385,018	0	1,385,018	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	273,334	7,217,061	7,490,395	-31,374	7,459,021	5.00
7.00	00700	OPERATION OF PLANT	0	1,140,533	1,140,533	18,943	1,159,476	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,794	76,794	0	76,794	8.00
9.00	00900	HOUSEKEEPING	0	328,774	328,774	0	328,774	9.00
10.00	01000	DIETARY	0	394,908	394,908	-301,897	93,011	10.00
11.00	01100	CAFETERIA	0	0	0	302,562	302,562	11.00
13.00	01300	NURSING ADMINISTRATION	235,408	272	235,680	0	235,680	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,607	10,607	11,766	22,373	14.00
15.00	01500	PHARMACY	178,367	1,208,747	1,387,114	0	1,387,114	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,266,843	183,369	1,450,212	-704,325	745,887	30.00
43.00	04300	NURSERY	0	0	0	208,543	208,543	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	329,253	194,688	523,941	-97,105	426,836	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	489,694	489,694	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	691,471	577,436	1,268,907	-286	1,268,621	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,985,467	1,985,467	0	1,985,467	60.00
65.00	06500	RESPIRATORY THERAPY	344,220	54,529	398,749	0	398,749	65.00
65.01	03950	SLEEP LAB	96,597	4,903	101,500	0	101,500	65.01
66.00	06600	PHYSICAL THERAPY	209,789	13,722	223,511	0	223,511	66.00
67.00	06700	OCCUPATIONAL THERAPY	62,629	53	62,682	0	62,682	67.00
68.00	06800	SPEECH PATHOLOGY	20,434	2,246	22,680	0	22,680	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24,240	24,240	126,045	150,285	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,939	25,939	0	25,939	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	90,538	15,510	106,048	0	106,048	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	94,018	21,044	115,062	-16,971	98,091	90.00
91.00	09100	EMERGENCY	767,619	1,600,414	2,368,033	-5,595	2,362,438	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,720,583	17,776,289	22,496,872	0	22,496,872	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	54,346	1,610	55,956	0	55,956	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	4,774,929	17,777,899	22,552,828	0	22,552,828	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A | Date/Time Prepared: 11/18/2021 5:26 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	-107,175	582,325	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	680,578	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,216	1,393,234	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-67,878	7,391,143	5.00
7.00	00700	OPERATION OF PLANT	0	1,159,476	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,794	8.00
9.00	00900	HOUSEKEEPING	0	328,774	9.00
10.00	01000	DIETARY	0	93,011	10.00
11.00	01100	CAFETERIA	-42,783	259,779	11.00
13.00	01300	NURSING ADMINISTRATION	-26	235,654	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	22,373	14.00
15.00	01500	PHARMACY	0	1,387,114	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	745,887	30.00
43.00	04300	NURSERY	0	208,543	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	426,836	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-61	489,633	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-50	1,268,571	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	1,985,467	60.00
65.00	06500	RESPIRATORY THERAPY	0	398,749	65.00
65.01	03950	SLEEP LAB	0	101,500	65.01
66.00	06600	PHYSICAL THERAPY	0	223,511	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	62,682	67.00
68.00	06800	SPEECH PATHOLOGY	0	22,680	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	150,285	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,939	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	106,048	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	98,091	90.00
91.00	09100	EMERGENCY	-570,921	1,791,517	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-780,678	21,716,194	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	55,956	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	0	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-780,678	21,772,150	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	0	302,804	1.00
	TOTALS		0	302,804	
	B - NURSERY RECLASS				
1.00	NURSERY	43.00	176,332	33,352	1.00
			176,332	33,352	
	C - DELIVERY & LABOR ROOM				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	414,057	78,316	1.00
			414,057	78,316	
	D - MEDICAL SUPPLIES CHARGED TO PATIENTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		126,045	1.00
2.00					2.00
3.00					3.00
4.00					4.00
5.00					5.00
6.00					6.00
7.00					7.00
			0	126,045	
	E - PANDEMIC				
1.00	OPERATION OF PLANT	7.00	0	18,943	1.00
2.00	DIETARY	10.00	0	907	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	11,766	3.00
	TOTALS		0	31,616	
	F - PANDEMIC WORKERS COMP				
1.00	NURSING ADMINISTRATION	13.00	0	436	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,142	2.00
	TOTALS		0	1,578	
500.00	Grand Total: Increases		590,389	573,711	500.00

RECLASSIFICATIONS | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-6 | Date/Time Prepared: 11/18/2021 5:26 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA					
1.00	DIETARY	10.00	0	302,804	0	1.00
	TOTALS		0	302,804		
	B - NURSERY RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	176,332	33,352		1.00
			176,332	33,352		
	C - DELIVERY & LABOR ROOM					
1.00	ADULTS & PEDIATRICS	30.00	414,057	78,316		1.00
			414,057	78,316		
	D - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	ADULTS & PEDIATRICS	30.00		2,268		1.00
2.00	NURSERY	43.00		1,141		2.00
3.00	OPERATING ROOM	50.00		97,105		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00		2,679		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00		286		5.00
6.00	CLINIC	90.00		16,971		6.00
7.00	EMERGENCY	91.00		5,595		7.00
			0	126,045		
	E - PANDEMIC					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	31,374	0	1.00
2.00	CAFETERIA	11.00	0	242	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	31,616		
	F - PANDEMIC WORKERS COMP					
1.00	NURSING ADMINISTRATION	13.00	436	0	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	1,142	0	0	2.00
	TOTALS		1,578	0		
500.00	Grand Total: Decreases		591,967	572,133		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part I | Date/Time Prepared: 11/18/2021 5:26 pm

		Beginning Balances	Acquisitions Purchases	Donation	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	696,652	0	0	0	0	1.00
2.00	Land Improvements	37,104	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,310,828	0	0	0	89,403	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,286,914	416,454	0	416,454	0	5.00
6.00	Movable Equipment	7,362,260	56,905	0	56,905	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,693,758	473,359	0	473,359	89,403	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	28,693,758	473,359	0	473,359	89,403	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	696,652	0	1.00
2.00	Land Improvements	37,104	0	2.00
3.00	Buildings and Fixtures	19,221,425	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	1,703,368	0	5.00
6.00	Movable Equipment	7,419,165	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,077,714	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	29,077,714	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 15-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet A-7 Part II Date/Time Prepared: 11/18/2021 5:26 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	689,252	0	0	0	248	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	680,578	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,369,830	0	0	0	248	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	689,500	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	680,578	2.00
3.00	Total (sum of lines 1-2)	0	1,370,078	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part III Date/Time Prepared: 11/18/2021 5:26 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	19,955,180	0	19,955,180	0.686271	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,122,534	0	9,122,534	0.313729	0	2.00
3.00	Total (sum of lines 1-2)	29,077,714	0	29,077,714	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	582,077	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	680,578	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,262,655	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	248	0	582,325	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	680,578	2.00
3.00	Total (sum of lines 1-2)	0	0	248	0	1,262,903	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8 | Date/Time Prepared: 11/18/2021 5:26 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-427,663	CAP REL COSTS-BLDG & FIXT	1.00	9	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	-11,908	ADMINISTRATIVE & GENERAL	5.00	9	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-575,421			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	2,723,724			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-42,783	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS REVENUE	B	-2,259	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8 | Date/Time Prepared: 11/18/2021 5:26 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS REVENUE	B	-61	DELIVERY ROOM & LABOR ROOM	52.00	0	33.01
33.02	MISCELLANEOUS REVENUE	B	-50	RADIOLOGY-DIAGNOSTIC	54.00	0	33.02
33.09	PROMOTIONAL ITEMS	A	-282	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ENTERTAINMENT	A	-26	NURSING ADMINISTRATION	13.00	0	33.10
33.11	CORPORATE SPONSORSHIP	A	-47,500	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.17	LOBBYING OFFSET	A	-474	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	PROVIDER ASSESSMENT TAX ADJUSTMENT	A	-1,188,081	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.20	PAVILION DEPRECIATION	A	-2,507	CAP REL COSTS-BLDG & FIXT	1.00	9	33.20
33.21	CARRYFORWARD ON HOSPITAL DEPR.	A	-104,668	CAP REL COSTS-BLDG & FIXT	1.00	9	33.21
33.24	Physician Fund Expense	A	-1,100,719	ADMINISTRATIVE & GENERAL	5.00	0	33.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-780,678				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: 15-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet A-8-1 Date/Time Prepared: 11/18/2021 5:26 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	359,944	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST	6,379	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Interest - A&G	118	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	6,623,873	4,274,806	3.01
3.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	180	180	3.02
3.03	15.00	PHARMACY	SVH CHARGEBACKS	4,000	4,000	3.03
3.04	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACKS	200,725	200,725	3.04
3.05	91.00	EMERGENCY	SVH CHARGEBACKS	-700	-700	3.05
3.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	857,089	848,873	3.06
3.07	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	427,663	0	3.07
3.08	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	5,411	433,074	3.08
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,484,682	5,760,958	5.00

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	G	ASCENSION SVH	1.00	ASCENSION SVH	1.00	6.00
7.00	G	ASCENSION	1.00	ASCENSION	1.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-1 Date/Time Prepared: 11/18/2021 5:26 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	359,944	0	1.00
2.00	6,379	0	2.00
3.00	118	0	3.00
3.01	2,349,067	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	8,216	0	3.06
3.07	427,663	9	3.07
3.08	-427,663	0	3.08
4.00	0	0	4.00
5.00	2,723,724		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.

	Type of Business	
6.00	ADMINISTRATION	6.00
7.00	ADMINISTRATION	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-2 | Date/Time Prepared: 11/18/2021 5:26 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	4,500	4,500	0	0	0	1.00
2.00	91.00	EMERGENCY	1,494,536	570,921	923,615	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,499,036	575,421	923,615		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	4,500	1.00
2.00	91.00	EMERGENCY	0	0	0	570,921	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	575,421	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I | Date/Time Prepared: 11/18/2021 5:26 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	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	582,325	582,325				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	680,578		680,578			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,393,234	0	0	1,393,234		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,391,143	87,418	102,167	79,543	7,660,271	5.00
7.00	00700	OPERATION OF PLANT	1,159,476	35,404	41,377	0	1,236,257	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	76,794	4,750	5,552	0	87,096	8.00
9.00	00900	HOUSEKEEPING	328,774	4,453	5,205	0	338,432	9.00
10.00	01000	DIETARY	93,011	16,522	19,309	0	128,842	10.00
11.00	01100	CAFETERIA	259,779	3,889	4,545	0	268,213	11.00
13.00	01300	NURSING ADMINISTRATION	235,654	1,069	1,249	69,524	307,496	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	22,373	0	0	0	22,373	14.00
15.00	01500	PHARMACY	1,387,114	0	0	52,775	1,439,889	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,007	12,864	0	23,871	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	745,887	65,330	76,352	199,811	1,087,380	30.00
43.00	04300	NURSERY	208,543	928	1,084	52,173	262,728	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	426,836	57,922	67,695	97,419	649,872	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	489,633	17,435	20,376	122,511	649,955	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,268,571	46,188	53,981	204,592	1,573,332	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,985,467	12,937	15,120	0	2,013,524	60.00
65.00	06500	RESPIRATORY THERAPY	398,749	14,599	17,063	101,848	532,259	65.00
65.01	03950	SLEEP LAB	101,500	3,147	3,678	28,581	136,906	65.01
66.00	06600	PHYSICAL THERAPY	223,511	23,009	26,891	62,072	335,483	66.00
67.00	06700	OCCUPATIONAL THERAPY	62,682	2,353	2,750	18,531	86,316	67.00
68.00	06800	SPEECH PATHOLOGY	22,680	0	0	6,046	28,726	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	150,285	12,491	14,599	0	177,375	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,939	0	0	0	25,939	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	106,048	11,066	12,934	26,788	156,836	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	98,091	0	0	27,818	125,909	90.00
91.00	09100	EMERGENCY	1,791,517	32,123	37,543	227,122	2,088,305	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,716,194	464,040	542,334	1,377,154	21,443,585	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,559	1,822	0	3,381	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	55,956	115,746	135,276	16,080	323,058	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	490	573	0	1,063	194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	490	573	0	1,063	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,772,150	582,325	680,578	1,393,234	21,772,150	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I | Date/Time Prepared: 11/18/2021 5:26 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,660,271					5.00
7.00	00700	OPERATION OF PLANT	671,070	1,907,327				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	47,278	19,717	154,091			8.00
9.00	00900	HOUSEKEEPING	183,709	18,485	0	540,626		9.00
10.00	01000	DIETARY	69,939	68,579	0	19,836	287,196	10.00
11.00	01100	CAFETERIA	145,592	16,143	0	4,669	0	11.00
13.00	01300	NURSING ADMINISTRATION	166,916	4,436	0	1,283	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,145	0	0	0	0	14.00
15.00	01500	PHARMACY	781,606	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,958	45,688	0	13,215	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	590,256	271,173	45,994	78,434	287,196	30.00
43.00	04300	NURSERY	142,615	3,851	5,594	1,114	0	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	352,766	240,426	18,490	69,541	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	352,811	72,368	13,135	20,932	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	854,042	191,719	24,653	55,453	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,092,989	53,698	0	15,532	0	60.00
65.00	06500	RESPIRATORY THERAPY	288,923	60,599	0	17,528	0	65.00
65.01	03950	SLEEP LAB	74,316	13,063	0	3,778	0	65.01
66.00	06600	PHYSICAL THERAPY	182,108	95,505	0	27,624	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	46,854	9,766	0	2,825	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,593	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	96,283	51,850	0	14,997	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,080	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,134	45,935	0	13,286	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	68,346	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,133,589	133,337	46,225	38,566	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,481,918	1,416,338	154,091	398,613	287,196	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,835	6,470	0	1,871	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	175,364	480,453	0	138,966	0	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	577	2,033	0	588	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	577	2,033	0	588	0	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,660,271	1,907,327	154,091	540,626	287,196	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I | Date/Time Prepared: 11/18/2021 5:26 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	434,617					11.00
13.00	01300	NURSING ADMINISTRATION	21,875	502,006				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	34,518			14.00
15.00	01500	PHARMACY	14,233	0	0	2,235,728		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	95,732	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	70,609	151,929	0	0	3,288	30.00
43.00	04300	NURSERY	16,971	36,517	0	0	1,167	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,398	63,257	0	0	6,989	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,848	85,742	0	0	2,740	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,156	0	0	0	28,253	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	28,132	60.00
65.00	06500	RESPIRATORY THERAPY	33,388	0	0	0	3,398	65.00
65.01	03950	SLEEP LAB	10,329	0	0	0	1,456	65.01
66.00	06600	PHYSICAL THERAPY	23,787	0	0	0	1,983	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,831	0	0	0	175	67.00
68.00	06800	SPEECH PATHOLOGY	1,803	0	0	0	110	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	29,437	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	5,081	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,495	0	0	2,235,728	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,758	0	0	0	0	90.00
91.00	09100	EMERGENCY	76,479	164,561	0	0	18,041	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	428,960	502,006	34,518	2,235,728	95,732	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,657	0	0	0	0	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	434,617	502,006	34,518	2,235,728	95,732	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I | Date/Time Prepared: 11/18/2021 5:26 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	2,586,259	0	2,586,259	30.00
43.00	04300	NURSERY	470,557	0	470,557	43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,430,739	0	1,430,739	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,237,531	0	1,237,531	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,794,608	0	2,794,608	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
60.00	06000	LABORATORY	3,203,875	0	3,203,875	60.00
65.00	06500	RESPIRATORY THERAPY	936,095	0	936,095	65.00
65.01	03950	SLEEP LAB	239,848	0	239,848	65.01
66.00	06600	PHYSICAL THERAPY	666,490	0	666,490	66.00
67.00	06700	OCCUPATIONAL THERAPY	151,767	0	151,767	67.00
68.00	06800	SPEECH PATHOLOGY	46,232	0	46,232	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	369,942	0	369,942	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,100	0	45,100	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,545,414	0	2,545,414	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	203,013	0	203,013	90.00
91.00	09100	EMERGENCY	3,699,103	0	3,699,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,626,573	0	20,626,573	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,557	0	13,557	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,123,498	0	1,123,498	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	4,261	0	4,261	194.00
194.01	07951	OTHER NRCC - FOUNDATION	4,261	0	4,261	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	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)	21,772,150	0	21,772,150	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II Date/Time Prepared: 11/18/2021 5:26 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	365,421	87,418	102,167	555,006	0	5.00
7.00	00700	OPERATION OF PLANT	600	35,404	41,377	77,381	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,750	5,552	10,302	0	8.00
9.00	00900	HOUSEKEEPING	0	4,453	5,205	9,658	0	9.00
10.00	01000	DIETARY	0	16,522	19,309	35,831	0	10.00
11.00	01100	CAFETERIA	0	3,889	4,545	8,434	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,069	1,249	2,318	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,007	12,864	23,871	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	699	65,330	76,352	142,381	0	30.00
43.00	04300	NURSERY	0	928	1,084	2,012	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	57,922	67,695	125,617	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,435	20,376	37,811	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	296,124	46,188	53,981	396,293	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	12,937	15,120	28,057	0	60.00
65.00	06500	RESPIRATORY THERAPY	23,862	14,599	17,063	55,524	0	65.00
65.01	03950	SLEEP LAB	1,749	3,147	3,678	8,574	0	65.01
66.00	06600	PHYSICAL THERAPY	0	23,009	26,891	49,900	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,353	2,750	5,103	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,491	14,599	27,090	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	11,066	12,934	24,000	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	32,123	37,543	69,666	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	688,455	464,040	542,334	1,694,829	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,559	1,822	3,381	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	115,746	135,276	251,022	0	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	490	573	1,063	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	490	573	1,063	0	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	688,455	582,325	680,578	1,951,358	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II | Date/Time Prepared: 11/18/2021 5:26 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	555,006					5.00
7.00	00700	OPERATION OF PLANT	48,621	126,002				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,425	1,303	15,030			8.00
9.00	00900	HOUSEKEEPING	13,310	1,221	0	24,189		9.00
10.00	01000	DIETARY	5,067	4,530	0	888	46,316	10.00
11.00	01100	CAFETERIA	10,549	1,066	0	209	0	11.00
13.00	01300	NURSING ADMINISTRATION	12,094	293	0	57	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	880	0	0	0	0	14.00
15.00	01500	PHARMACY	56,629	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	939	3,018	0	591	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,766	17,914	4,486	3,509	46,316	30.00
43.00	04300	NURSERY	10,333	254	546	50	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,559	15,883	1,803	3,111	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,562	4,781	1,281	937	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	61,878	12,665	2,405	2,481	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	79,190	3,547	0	695	0	60.00
65.00	06500	RESPIRATORY THERAPY	20,933	4,003	0	784	0	65.00
65.01	03950	SLEEP LAB	5,384	863	0	169	0	65.01
66.00	06600	PHYSICAL THERAPY	13,194	6,309	0	1,236	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,395	645	0	126	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,130	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,976	3,425	0	671	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,020	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,168	3,035	0	594	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,952	0	0	0	0	90.00
91.00	09100	EMERGENCY	82,129	8,809	4,509	1,726	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	542,083	93,564	15,030	17,834	46,316	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	133	427	0	84	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,706	31,743	0	6,219	0	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	42	134	0	26	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	42	134	0	26	0	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	555,006	126,002	15,030	24,189	46,316	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II | Date/Time Prepared: 11/18/2021 5:26 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	20,258					11.00
13.00	01300	NURSING ADMINISTRATION	1,020	15,782				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	880			14.00
15.00	01500	PHARMACY	663	0	0	57,292		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	28,419	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,291	4,776	0	0	975	30.00
43.00	04300	NURSERY	791	1,148	0	0	346	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,370	1,989	0	0	2,072	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,857	2,696	0	0	812	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,130	0	0	0	8,411	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	8,341	60.00
65.00	06500	RESPIRATORY THERAPY	1,556	0	0	0	1,008	65.00
65.01	03950	SLEEP LAB	481	0	0	0	432	65.01
66.00	06600	PHYSICAL THERAPY	1,109	0	0	0	588	66.00
67.00	06700	OCCUPATIONAL THERAPY	272	0	0	0	52	67.00
68.00	06800	SPEECH PATHOLOGY	84	0	0	0	33	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	750	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	130	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	396	0	0	57,292	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	408	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,566	5,173	0	0	5,349	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,994	15,782	880	57,292	28,419	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	264	0	0	0	0	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	20,258	15,782	880	57,292	28,419	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II | Date/Time Prepared: 11/18/2021 5:26 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	266,414	0	266,414		30.00
43.00	04300	NURSERY	15,480	0	15,480		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	177,404	0	177,404		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	75,737	0	75,737		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	487,263	0	487,263		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	119,830	0	119,830		60.00
65.00	06500	RESPIRATORY THERAPY	83,808	0	83,808		65.00
65.01	03950	SLEEP LAB	15,903	0	15,903		65.01
66.00	06600	PHYSICAL THERAPY	72,336	0	72,336		66.00
67.00	06700	OCCUPATIONAL THERAPY	9,593	0	9,593		67.00
68.00	06800	SPEECH PATHOLOGY	1,247	0	1,247		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,912	0	38,912		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,150	0	1,150		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	91,485	0	91,485		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	5,360	0	5,360		90.00
91.00	09100	EMERGENCY	180,927	0	180,927		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,642,849	0	1,642,849		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,025	0	4,025		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	301,954	0	301,954		192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	1,265	0	1,265		194.00
194.01	07951	OTHER NRCC - FOUNDATION	1,265	0	1,265		194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0		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)	1,951,358	0	1,951,358		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/18/2021 5:26 pm

		Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	78,458					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		78,458				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	4,708,788			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,778	11,778	268,834	-7,660,271	14,111,879	5.00
7.00	00700	OPERATION OF PLANT	4,770	4,770	0	0	1,236,257	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	640	640	0	0	87,096	8.00
9.00	00900	HOUSEKEEPING	600	600	0	0	338,432	9.00
10.00	01000	DIETARY	2,226	2,226	0	0	128,842	10.00
11.00	01100	CAFETERIA	524	524	0	0	268,213	11.00
13.00	01300	NURSING ADMINISTRATION	144	144	234,973	0	307,496	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	22,373	14.00
15.00	01500	PHARMACY	0	0	178,367	0	1,439,889	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,483	1,483	0	0	23,871	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,802	8,802	675,311	0	1,087,380	30.00
43.00	04300	NURSERY	125	125	176,332	0	262,728	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,804	7,804	329,253	0	649,872	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,349	2,349	414,057	0	649,955	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,223	6,223	691,471	0	1,573,332	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,743	1,743	0	0	2,013,524	60.00
65.00	06500	RESPIRATORY THERAPY	1,967	1,967	344,220	0	532,259	65.00
65.01	03950	SLEEP LAB	424	424	96,597	0	136,906	65.01
66.00	06600	PHYSICAL THERAPY	3,100	3,100	209,789	0	335,483	66.00
67.00	06700	OCCUPATIONAL THERAPY	317	317	62,629	0	86,316	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	20,434	0	28,726	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,683	1,683	0	0	177,375	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	25,939	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,491	1,491	90,538	0	156,836	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	94,018	0	125,909	90.00
91.00	09100	EMERGENCY	4,328	4,328	767,619	0	2,088,305	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,521	62,521	4,654,442	-7,660,271	13,783,314	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	210	210	0	0	3,381	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,595	15,595	54,346	0	323,058	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	66	66	0	0	1,063	194.00
194.01	07951	OTHER NRCC - FOUNDATION	66	66	0	0	1,063	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	582,325	680,578	1,393,234		7,660,271	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.422124	8.674425	0.295880		0.542824	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		555,006	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.039329	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: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/18/2021 5:26 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	61,910					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	640	70,704				8.00
9.00	00900	HOUSEKEEPING	600	0	60,670			9.00
10.00	01000	DIETARY	2,226	0	2,226	100		10.00
11.00	01100	CAFETERIA	524	0	524	0	122,232	11.00
13.00	01300	NURSING ADMINISTRATION	144	0	144	0	6,152	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	4,003	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,483	0	1,483	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,802	21,104	8,802	100	19,858	30.00
43.00	04300	NURSERY	125	2,567	125	0	4,773	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,804	8,484	7,804	0	8,268	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,349	6,027	2,349	0	11,207	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,223	11,312	6,223	0	18,887	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,743	0	1,743	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,967	0	1,967	0	9,390	65.00
65.01	03950	SLEEP LAB	424	0	424	0	2,905	65.01
66.00	06600	PHYSICAL THERAPY	3,100	0	3,100	0	6,690	66.00
67.00	06700	OCCUPATIONAL THERAPY	317	0	317	0	1,640	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	507	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,683	0	1,683	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,491	0	1,491	0	2,389	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	2,463	90.00
91.00	09100	EMERGENCY	4,328	21,210	4,328	0	21,509	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,973	70,704	44,733	100	120,641	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	210	0	210	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,595	0	15,595	0	1,591	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	66	0	66	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	66	0	66	0	0	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,907,327	154,091	540,626	287,196	434,617	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.808060	2.179382	8.910928	2,871.960000	3.555673	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	126,002	15,030	24,189	46,316	20,258	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.035245	0.212576	0.398698	463.160000	0.165734	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: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/18/2021 5:26 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	65,615					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	176,225				14.00
15.00	01500	PHARMACY	0	0	10,000			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	81,362,661		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,858	0	0	2,793,555		30.00
43.00	04300	NURSERY	4,773	0	0	991,331		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,268	0	0	5,938,297		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,207	0	0	2,327,805		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,031,241		54.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0	23,901,028		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,886,942		65.00
65.01	03950	SLEEP LAB	0	0	0	1,237,316		65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	1,685,117		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	148,345		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	93,803		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	150,286	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,939	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	10,000	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	21,509	0	0	15,327,881		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	65,615	176,225	10,000	81,362,661		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0		194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	0	0	0		194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	502,006	34,518	2,235,728	95,732		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.650781	0.195875	223.572800	0.001177		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,782	880	57,292	28,419		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.240524	0.004994	5.729200	0.000349		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/18/2021 5:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,586,259		2,586,259	0	0	30.00
43.00	04300	NURSERY	470,557		470,557	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,430,739		1,430,739	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,237,531		1,237,531	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,794,608		2,794,608	0	0	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	3,203,875		3,203,875	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	936,095	0	936,095	0	0	65.00
65.01	03950	SLEEP LAB	239,848	0	239,848	0	0	65.01
66.00	06600	PHYSICAL THERAPY	666,490	0	666,490	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	151,767	0	151,767	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	46,232	0	46,232	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	369,942		369,942	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,100		45,100	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,545,414		2,545,414	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	203,013		203,013	0	0	90.00
91.00	09100	EMERGENCY	3,699,103		3,699,103	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	342,188		342,188		0	92.00
200.00		Subtotal (see instructions)	20,968,761	0	20,968,761	0	0	200.00
201.00		Less Observation Beds	342,188		342,188		0	201.00
202.00		Total (see instructions)	20,626,573	0	20,626,573	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/18/2021 5:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	2,424,155		2,424,155			30.00
43.00	04300	NURSERY	991,331		991,331			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,623,816	4,314,481	5,938,297	0.240934	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,732,984	594,821	2,327,805	0.531630	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	516,631	23,514,610	24,031,241	0.116291	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,206,298	22,694,730	23,901,028	0.134048	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	568,542	2,318,400	2,886,942	0.324251	0.000000	65.00
65.01	03950	SLEEP LAB	0	1,237,316	1,237,316	0.193845	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	38,320	1,646,797	1,685,117	0.395516	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,927	133,418	148,345	1.023068	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	3,935	89,868	93,803	0.492863	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	368,884	738,606	1,107,490	0.334036	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	33,262	33,262	1.355902	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	988,527	7,194,951	8,183,478	0.311043	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	685,229	685,229	0.296270	0.000000	90.00
91.00	09100	EMERGENCY	195,102	15,132,779	15,327,881	0.241332	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	45,261	324,139	369,400	0.926335	0.000000	92.00
200.00		Subtotal (see instructions)	10,718,713	80,653,407	91,372,120			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,718,713	80,653,407	91,372,120			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/18/2021 5:26 pm
	Title XVIII	Hospital	Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
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
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
65.01	03950	SLEEP LAB	0.000000	65.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/18/2021 5:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,586,259		2,586,259	0	2,586,259	30.00
43.00	04300	NURSERY	470,557		470,557	0	470,557	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,430,739		1,430,739	0	1,430,739	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,237,531		1,237,531	0	1,237,531	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,794,608		2,794,608	0	2,794,608	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	3,203,875		3,203,875	0	3,203,875	60.00
65.00	06500	RESPIRATORY THERAPY	936,095	0	936,095	0	936,095	65.00
65.01	03950	SLEEP LAB	239,848	0	239,848	0	239,848	65.01
66.00	06600	PHYSICAL THERAPY	666,490	0	666,490	0	666,490	66.00
67.00	06700	OCCUPATIONAL THERAPY	151,767	0	151,767	0	151,767	67.00
68.00	06800	SPEECH PATHOLOGY	46,232	0	46,232	0	46,232	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	369,942		369,942	0	369,942	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,100		45,100	0	45,100	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,545,414		2,545,414	0	2,545,414	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	203,013		203,013	0	203,013	90.00
91.00	09100	EMERGENCY	3,699,103		3,699,103	0	3,699,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	342,188		342,188		342,188	92.00
200.00		Subtotal (see instructions)	20,968,761	0	20,968,761	0	20,968,761	200.00
201.00		Less Observation Beds	342,188		342,188		342,188	201.00
202.00		Total (see instructions)	20,626,573	0	20,626,573	0	20,626,573	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/18/2021 5:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	2,424,155		2,424,155			30.00
43.00	04300	NURSERY	991,331		991,331			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,623,816	4,314,481	5,938,297	0.240934	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,732,984	594,821	2,327,805	0.531630	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	516,631	23,514,610	24,031,241	0.116291	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,206,298	22,694,730	23,901,028	0.134048	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	568,542	2,318,400	2,886,942	0.324251	0.000000	65.00
65.01	03950	SLEEP LAB	0	1,237,316	1,237,316	0.193845	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	38,320	1,646,797	1,685,117	0.395516	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,927	133,418	148,345	1.023068	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	3,935	89,868	93,803	0.492863	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	368,884	738,606	1,107,490	0.334036	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	33,262	33,262	1.355902	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	988,527	7,194,951	8,183,478	0.311043	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	685,229	685,229	0.296270	0.000000	90.00
91.00	09100	EMERGENCY	195,102	15,132,779	15,327,881	0.241332	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	45,261	324,139	369,400	0.926335	0.000000	92.00
200.00		Subtotal (see instructions)	10,718,713	80,653,407	91,372,120			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,718,713	80,653,407	91,372,120			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/18/2021 5:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
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
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
65.01	03950	SLEEP LAB	0.000000	65.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part II Date/Time Prepared: 11/18/2021 5:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	177,404	5,938,297	0.029875	27,439	820	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	75,737	2,327,805	0.032536	4,670	152	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	487,263	24,031,241	0.020276	104,492	2,119	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	119,830	23,901,028	0.005014	137,055	687	60.00
65.00	06500	RESPIRATORY THERAPY	83,808	2,886,942	0.029030	165,591	4,807	65.00
65.01	03950	SLEEP LAB	15,903	1,237,316	0.012853	0	0	65.01
66.00	06600	PHYSICAL THERAPY	72,336	1,685,117	0.042926	11,016	473	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,593	148,345	0.064667	5,100	330	67.00
68.00	06800	SPEECH PATHOLOGY	1,247	93,803	0.013294	2,655	35	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,912	1,107,490	0.035135	64,155	2,254	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,150	33,262	0.034574	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	91,485	8,183,478	0.011179	128,055	1,432	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,360	685,229	0.007822	0	0	90.00
91.00	09100	EMERGENCY	180,927	15,327,881	0.011804	1,150	14	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	35,249	369,400	0.095422	0	0	92.00
200.00		Total (lines 50 through 199)	1,396,204	87,956,634		651,378	13,123	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV | Date/Time Prepared: 11/18/2021 5:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03950	SLEEP LAB	0	0	0	0	0	65.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/18/2021 5:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	5,938,297	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,327,805	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,031,241	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	23,901,028	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,886,942	0.000000	65.00
65.01	03950	SLEEP LAB	0	0	0	1,237,316	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	1,685,117	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	148,345	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	93,803	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,107,490	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	33,262	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,183,478	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	685,229	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	15,327,881	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	369,400	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	87,956,634		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV | Date/Time Prepared: 11/18/2021 5:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	27,439	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	4,670	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	104,492	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	137,055	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	165,591	0	0	0	65.00
65.01	03950	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	11,016	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	5,100	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,655	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	64,155	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	128,055	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	1,150	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		651,378	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/18/2021 5:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.240934	0	1,053,316	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.531630	0	2,382	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116291	0	5,607,058	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.134048	0	3,687,097	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.324251	0	625,174	0	0	65.00
65.01	03950	SLEEP LAB	0.193845	0	3,030	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.395516	0	452,179	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.023068	0	29,667	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.492863	0	19,261	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.334036	0	176,375	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.355902	0	7,896	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.311043	0	2,750,146	539	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.296270	0	306	654	0	90.00
91.00	09100	EMERGENCY	0.241332	0	2,812,600	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.926335	0	81,873	0	0	92.00
200.00		Subtotal (see instructions)		0	17,308,360	1,193	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	17,308,360	1,193	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/18/2021 5:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	253,780	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,266	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	652,050	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	494,248	0	60.00
65.00	06500	RESPIRATORY THERAPY	202,713	0	65.00
65.01	03950	SLEEP LAB	587	0	65.01
66.00	06600	PHYSICAL THERAPY	178,844	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,351	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,493	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,916	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,706	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	855,414	168	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	91	194	90.00
91.00	09100	EMERGENCY	678,770	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	75,842	0	92.00
200.00		Subtotal (see instructions)	3,503,071	362	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	3,503,071	362	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1301
Component CCN: 15-Z301
Period: From 07/01/2020 To 06/30/2021
Worksheet D Part V
Date/Time Prepared: 11/18/2021 5:26 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.240934	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.531630	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116291	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.134048	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.324251	0	0	0	0	65.00
65.01	03950	SLEEP LAB	0.193845	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.395516	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.023068	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.492863	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.334036	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.355902	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.311043	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.296270	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.241332	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.926335	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1301 | Component CCN: 15-Z301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V | Date/Time Prepared: 11/18/2021 5:26 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		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
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.01	03950	SLEEP LAB	0	0	65.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	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 INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part III Date/Time Prepared: 11/18/2021 5:26 pm

Title XIX | Hospital | Cost

		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
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	1,310	0.00	30	30.00
43.00	04300	NURSERY		0	434	0.00	46	43.00
200.00		Total (lines 30 through 199)		0	1,744		76	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
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: 15-1301

Period: From 07/01/2020 To 06/30/2021

Worksheet D Part IV

Date/Time Prepared: 11/18/2021 5:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03950	SLEEP LAB	0	0	0	0	0	65.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/18/2021 5:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	5,938,297	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,327,805	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,031,241	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	23,901,028	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,886,942	0.000000	65.00
65.01	03950	SLEEP LAB	0	0	0	1,237,316	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	1,685,117	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	148,345	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	93,803	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,107,490	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	33,262	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,183,478	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	685,229	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	15,327,881	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	369,400	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	87,956,634		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV | Date/Time Prepared: 11/18/2021 5:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	59,969	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	128,981	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	23,885	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	79,157	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	26,133	0	0	0	65.00
65.01	03950	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	13,772	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	32,650	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	22,576	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		387,123	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/18/2021 5:26 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,368	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,310	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,129	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	29	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)	29	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)	235	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)	9	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)	18	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	216.95	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	216.95	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,586,259	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)	109,651	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,476,608	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)	2,476,608	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)	1,890.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	444,277	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)	444,277	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/18/2021 5:26 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	165,733	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	610,010	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)	17,015	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	34,030	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	51,045	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)	181	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,890.54	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	342,188	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/18/2021 5:26 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	266,414	2,586,259	0.103011	342,188	35,249	90.00
91.00	Nursing School cost	0	2,586,259	0.000000	342,188	0	91.00
92.00	Allied health cost	0	2,586,259	0.000000	342,188	0	92.00
93.00	All other Medical Education	0	2,586,259	0.000000	342,188	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/18/2021 5:26 pm
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,368	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,310	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,129	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	29	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)	29	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)	30	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)	434	15.00
16.00	Nursery days (title V or XIX only)	46	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	216.95	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	216.95	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,586,259	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)	109,651	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,476,608	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)	2,476,608	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)	1,890.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	56,716	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	56,716	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/18/2021 5:26 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	470,557	434	1,084.23	46	49,875	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	125,086	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	231,677	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)	181	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,890.54	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	342,188	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/18/2021 5:26 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	266,414	2,586,259	0.103011	342,188	35,249	90.00
91.00	Nursing School cost	0	2,586,259	0.000000	342,188	0	91.00
92.00	Allied health cost	0	2,586,259	0.000000	342,188	0	92.00
93.00	All other Medical Education	0	2,586,259	0.000000	342,188	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/18/2021 5:26 pm
	Title XVIII	Hospital	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		414,581		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.240934	27,439	6,611	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.531630	4,670	2,483	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116291	104,492	12,151	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.134048	137,055	18,372	60.00
65.00	06500	RESPIRATORY THERAPY	0.324251	165,591	53,693	65.00
65.01	03950	SLEEP LAB	0.193845	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.395516	11,016	4,357	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.023068	5,100	5,218	67.00
68.00	06800	SPEECH PATHOLOGY	0.492863	2,655	1,309	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.334036	64,155	21,430	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.355902	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.311043	128,055	39,831	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.296270	0	0	90.00
91.00	09100	EMERGENCY	0.241332	1,150	278	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.926335	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		651,378	165,733	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)		651,378		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1301 | Component CCN: 15-Z301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 11/18/2021 5:26 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.240934	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.531630	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116291	3,382	393	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.134048	4,798	643	60.00
65.00	06500	RESPIRATORY THERAPY	0.324251	5,472	1,774	65.00
65.01	03950	SLEEP LAB	0.193845	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.395516	8,094	3,201	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.023068	3,276	3,352	67.00
68.00	06800	SPEECH PATHOLOGY	0.492863	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.334036	3,984	1,331	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.355902	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.311043	4,213	1,310	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.296270	0	0	90.00
91.00	09100	EMERGENCY	0.241332	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.926335	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		33,219	12,004	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)		33,219		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 11/18/2021 5:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		54,503		30.00
43.00	04300	NURSERY		54,929		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.240934	59,969	14,449	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.531630	128,981	68,570	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116291	23,885	2,778	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.134048	79,157	10,611	60.00
65.00	06500	RESPIRATORY THERAPY	0.324251	26,133	8,474	65.00
65.01	03950	SLEEP LAB	0.193845	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.395516	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.023068	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.492863	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.334036	13,772	4,600	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.355902	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.311043	32,650	10,156	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.296270	0	0	90.00
91.00	09100	EMERGENCY	0.241332	22,576	5,448	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.926335	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		387,123	125,086	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)		387,123		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E Part B Date/Time Prepared: 11/18/2021 5:26 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,503,433	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,503,433	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	3,538,467	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	38,424	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,611,748	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)	888,295	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)	888,295	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	888,295	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)	544,965	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	354,227	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	399,505	36.00
37.00	Subtotal (see instructions)	1,242,522	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)	1,242,522	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	2,023,266	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)	-780,744	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: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-1 Part I Date/Time Prepared: 11/18/2021 5:26 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		602,158		2,023,266	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)		602,158		2,023,266	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		59,876		780,744	6.02
7.00	Total Medicare program liability (see instructions)		542,282		1,242,522	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: 15-1301 | Component CCN: 15-Z301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-1 Part I | Date/Time Prepared: 11/18/2021 5:26 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		66,744		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		66,744		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		3,065		0	6.02
7.00	Total Medicare program liability (see instructions)		63,679		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1301 | Component CCN: 15-Z301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-2 | Date/Time Prepared: 11/18/2021 5:26 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	51,555	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	12,124	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	27	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	63,679	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	63,679	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	63,679	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	63,679	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	63,679	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	66,744	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	-3,065	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-3 Part V Date/Time Prepared: 11/18/2021 5:26 pm

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	610,010	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	610,010	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	616,110	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	616,110	19.00
20.00	Deductibles (exclude professional component)	77,932	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	538,178	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	538,178	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	6,314	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	4,104	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,398	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	542,282	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	542,282	30.00
30.01	Sequestration adjustment (see instructions)	0	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	602,158	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-59,876	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-3 Part VII Date/Time Prepared: 11/18/2021 5:26 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	231,677		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)	231,677	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)	231,677	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	58,905		8.00
9.00	Ancillary service charges	387,123	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)	446,028	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)	446,028	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	214,351	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)	231,677	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)	231,677	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)	231,677	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)	231,677	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	231,677	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)	231,677	0	40.00
41.00	Interim payments	231,677	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G | Date/Time Prepared: 11/18/2021 5:26 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	475	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	8,291,343	0	0	0	4.00
5.00	Other receivable	897,286	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,097,335	0	0	0	6.00
7.00	Inventory	328,679	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,420,448	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	696,652	0	0	0	12.00
13.00	Land improvements	37,104	0	0	0	13.00
14.00	Accumulated depreciation	-5,153	0	0	0	14.00
15.00	Buildings	19,221,425	0	0	0	15.00
16.00	Accumulated depreciation	-11,771,468	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	1,703,369	0	0	0	19.00
20.00	Accumulated depreciation	-666,354	0	0	0	20.00
21.00	Automobiles and trucks	35,320	0	0	0	21.00
22.00	Accumulated depreciation	-35,320	0	0	0	22.00
23.00	Major movable equipment	7,383,844	0	0	0	23.00
24.00	Accumulated depreciation	-6,217,294	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	10,382,125	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	148,857	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	148,857	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	14,951,430	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,126,158	0	0	0	37.00
38.00	Salaries, wages, and fees payable	461,305	0	0	0	38.00
39.00	Payroll taxes payable	53,642	0	0	0	39.00
40.00	Notes and loans payable (short term)	207,003	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,995,069	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,843,177	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	12,675,287	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	245,551	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12,920,838	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	18,764,015	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-3,812,585				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)	-3,812,585	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	14,951,430	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G-1 | Date/Time Prepared: 11/18/2021 5:26 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-4,735,876		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,444,179				2.00
3.00	Total (sum of line 1 and line 2)		708,303		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	Rounding	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)		708,303		0		11.00
12.00	Transfer from Affiliates	4,520,888		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)		4,520,888		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-3,812,585		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	Rounding		0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Transfer from Affiliates		0		12.00
13.00			0		13.00
14.00			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: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/18/2021 5:26 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,126,827		6,126,827	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,126,827		6,126,827	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,126,827		6,126,827	17.00
18.00	Ancillary services	5,329,880	63,532,902	68,862,782	18.00
19.00	Outpatient services	240,055	16,142,455	16,382,510	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,696,762	79,675,357	91,372,119	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,552,828		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)		22,552,828		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1301 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G-3 | Date/Time Prepared: 11/18/2021 5:26 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	91,372,119	1.00
2.00	Less contractual allowances and discounts on patients' accounts	65,458,703	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,913,416	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,552,828	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,360,588	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	22,228	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	42,783	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	1,823	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	392,843	22.00
23.00	Governmental appropriations	0	23.00
24.00	Other	62,169	24.00
24.50	COVID-19 PHE Funding	1,561,745	24.50
25.00	Total other income (sum of lines 6-24)	2,083,591	25.00
26.00	Total (line 5 plus line 25)	5,444,179	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)	5,444,179	29.00