

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: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/30/2022 2:34 pm
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 5/30/2022	Time: 2:34 pm
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL SOUTH ( 15-0128 ) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	1,081,000	-146,041	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing Bed - SNF	0	0	0	0	0	5.00
6.00 Swing Bed - NF	0	0	0	0	0	6.00
200.00 Total	0	1,081,000	-146,041	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/30/2022 2:34 pm
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1.00	Hospital and Hospital Health Care Complex Address:	2.00	3.00	4.00	1.00
2.00	Street: 1402 EAST COUNTY LINE ROAD SOUTH	PO Box:	Zip Code: 46227	County: MARION	2.00
	City: INDIANAPOLIS	State: IN			

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		

Hospital and Hospital-Based Component Identification:										
3.00	Hospital	COMMUNITY HOSPITAL SOUTH	150128	26900	1	07/01/1966	N	P	P	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									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:		To:		
						1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2021		12/31/2021		20.00
21.00	Type of Control (see instructions)					2				21.00
						1.00	2.00	3.00		

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0128			Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/30/2022 2:34 pm		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,616	288	0	37	9,027	30	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
						Urban/Rural	S	Date of Geogr	
						1.00		2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00		2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00		2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	N	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
<b>Prospective Payment System (PPS)-Capital</b>									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
<b>Teaching Hospitals</b>									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					Y	Y		56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00

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		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code					
		1.00	2.00	3.00					
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00		
		Y/N	IME	Direct GME	IME	Direct GME			
		1.00	2.00	3.00	4.00	5.00			
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00		
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03		
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06		
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count				
		1.00	2.00	3.00	4.00				
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.10		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.20		
						1.00			
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01		
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00		
		Unweighted FTEs Nonprovi- der Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))					
		1.00	2.00	3.00					
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00

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	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	2.18	0.000000		66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MEDICINE	1350	0.00	6.45	0.000000		67.00
					1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N				70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0		71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N				75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0		76.00

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						1.00			
<b>Long Term Care Hospital PPS</b>									
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.					N		81.00	
<b>TEFRA Providers</b>									
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.							86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					N		87.00	
						V	XIX		
						1.00	2.00		
<b>Title V and XIX Services</b>									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.					N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.					N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.					N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.					N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.					N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.06	
<b>Rural Providers</b>									
105.00	Does this hospital qualify as a CAH?					N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)							106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)							107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					N		108.00	
						Physical	Occupational	Speech	Respiratory
						1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.								109.00
						1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.						N		110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/30/2022 2:34 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
<b>Miscellaneous Cost Reporting Information</b>				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,297,565	0	118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
<b>Transplant Center Information</b>				
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
<b>All Providers</b>				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0720	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0128		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/30/2022 2:34 pm		
1.00		2.00		3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name: COMMUNITY HEALTH NETWORK	Contractor's Name: WISCONSIN PHYSICIANS SERVICES		Contractor's Number: 08101				141.00
142.00	Street: 1500 NORTH RITTER AVENUE	PO Box:						142.00
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46219-3095				143.00
144.00 Are provider based physicians' costs included in Worksheet A?								
Y								
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.								
Y								
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								
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								
N								
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								
N								
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								
N								
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
155.00 Hospital								
N								
156.00 Subprovider - IPF								
N								
157.00 Subprovider - IRF								
N								
158.00 SUBPROVIDER								
N								
159.00 SNF								
N								
160.00 HOME HEALTH AGENCY								
N								
161.00 CMHC								
N								
165.00 Multi campus								
Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								
N								
		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								
167.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								
Y								
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)								
168.01								
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)								
9.99								
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								
9.99								
		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								
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								
N								
0								



HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0128		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part II Date/Time Prepared: 5/30/2022 2:34 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	03/31/2022	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			Y			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
						Y/N	
						1.00	
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	05/02/2022	Y	05/02/2022
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: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/30/2022 2:34 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00		2.00	
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SHIRLEY		BI SHOP	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH NETWORK			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-355-4135		SBI SHOP@ECOMMUNITY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/30/2022 2:34 pm
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	NETWORK DIRECTOR OF REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0128

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2022 2:34 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	157	57,305	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		157	57,305	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		169	61,685	0.00	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)		169				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: 15-0128

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2022 2:34 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	10,289	1,465	36,766			1.00
2.00 HMO and other (see instructions)	9,850	8,048				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	10,289	1,465	36,766			7.00
8.00 INTENSIVE CARE UNIT	935	0	3,110			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		1,455	2,597			13.00
14.00 Total (see instructions)	11,224	2,920	42,473	8.63	899.02	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			97			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)				8.63	899.02	27.00
28.00 Observation Bed Days		833	5,441			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			465			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	30	615			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: 15-0128

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2022 2:34 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,407	258	9,419	1.00
2.00 HMO and other (see instructions)			1,822	1,926		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	2,407	258	9,419	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 WAGE INDEX INFORMATION

Provider CCN: 15-0128

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/30/2022 2:34 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	72,647,184	-353,297	72,293,887	1,869,963.00	38.66
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		704,384	0	704,384	4,832.00	145.77
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		371,499	0	371,499	4,056.00	91.59
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		679,384	-4,923	674,461	23,572.00	28.61
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		4,783,557	0	4,783,557	60,180.00	79.49
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		1,822,248	0	1,822,248	22,148.00	82.28
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		38,535,628	0	38,535,628	473,779.00	81.34
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		18,070,031	0	18,070,031		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		214,985	0	214,985		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		58,191	0	58,191		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		48,846	0	48,846		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		5,446,846	0	5,446,846		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0128

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/30/2022 2:34 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)	0	0	0			25.53
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	4,481,318	-15,041	4,466,277	114,796.00	38.91	27.00
28.00	Administrative & General under contract (see inst.)	4,470,122	0	4,470,122	35,896.00	124.53	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	843,316	-2,523	840,793	30,274.00	27.77	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	1,564,564	-2,958	1,561,606	86,416.00	18.07	32.00
33.00	Housekeeping under contract (see instructions)	310,733	0	310,733	7,072.00	43.94	33.00
34.00	Dietary	1,376,929	-895,933	480,996	25,113.00	19.15	34.00
35.00	Dietary under contract (see instructions)	273,690	0	273,690	4,160.00	65.79	35.00
36.00	Cafeteria	0	889,585	889,585	45,840.00	19.41	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	351,881	-752	351,129	19,419.00	18.08	38.00
39.00	Central Services and Supply	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	41.00
42.00	Social Service	1,316,014	-2,240	1,313,774	31,460.00	41.76	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00



HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0128

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/30/2022 2:34 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	77,330,230	-353,297	76,976,933	1,913,035.00	40.24	1.00
2.00	Excluded area salaries (see instructions)	679,384	-4,923	674,461	23,572.00	28.61	2.00
3.00	Subtotal salaries (line 1 minus line 2)	76,650,846	-348,374	76,302,472	1,889,463.00	40.38	3.00
4.00	Subtotal other wages & related costs (see inst.)	45,141,433	0	45,141,433	556,107.00	81.17	4.00
5.00	Subtotal wage-related costs (see inst.)	23,575,068	0	23,575,068	0.00	30.90	5.00
6.00	Total (sum of lines 3 thru 5)	145,367,347	-348,374	145,018,973	2,445,570.00	59.30	6.00
7.00	Total overhead cost (see instructions)	14,988,567	-29,862	14,958,705	400,446.00	37.36	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2022 2:34 pm
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	2,865,746	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	36,890	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	618,716	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	6,651,675	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	2,075,965	9.00
10.00	Dental, Hearing and Vision Plan	71,688	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	38,921	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	563,703	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	163,835	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	5,242,504	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	62,408	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	18,392,051	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 15-0128

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
5/30/2022 2:34 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	4,783,557	18,392,051	1.00
2.00	Hospital	4,783,557	18,392,051	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/30/2022 2:34 pm
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				1.00		
<b>Uncompensated and indigent care cost computation</b>						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.202246	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			51,010,518	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			-15,928,632	5.00	
6.00	Medicaid charges			215,324,260	6.00	
7.00	Medicaid cost (line 1 times line 6)			43,548,470	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			8,466,584	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP			0	9.00	
10.00	Stand-alone CHIP charges			0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			8,466,584	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)	9,206,183	1,692,114	10,898,297	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,861,914	1,692,114	3,554,028	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	546	0	546	22.00	
23.00	Cost of charity care (line 21 minus line 22)	1,861,368	1,692,114	3,553,482	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)			13,471,210	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			173,928	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			267,581	27.01	
28.00	Non-Medicare bad debt expense (see instructions)			13,203,629	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			2,764,034	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			6,317,516	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			14,784,100	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0128

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

Worksheet A  
Date/Time Prepared:  
5/30/2022 2:34 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	10,274,659	10,274,659	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	7,734,831	7,734,831	2.00	
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	28	0	28	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	4,481,318	83,440,788	87,922,106	-9,399,735	78,522,371	5.00
7.00	00700	OPERATION OF PLANT	843,316	4,012,107	4,855,423	-131,457	4,723,966	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	671,661	671,661	0	671,661	8.00
9.00	00900	HOUSEKEEPING	1,564,564	1,118,397	2,682,961	-13,185	2,669,776	9.00
10.00	01000	DIETARY	1,376,929	1,614,525	2,991,454	-1,942,740	1,048,714	10.00
11.00	01100	CAFETERIA	0	0	0	1,914,656	1,914,656	11.00
13.00	01300	NURSING ADMINISTRATION	351,881	84,398	436,279	0	436,279	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,316,014	369,753	1,685,767	-1,838	1,683,929	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	25,539,484	19,826,947	45,366,431	-5,856,296	39,510,135	30.00
31.00	03100	INTENSIVE CARE UNIT	3,536,328	1,653,406	5,189,734	-460,523	4,729,211	31.00
43.00	04300	NURSERY	0	0	0	783,201	783,201	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	3,897,668	18,916,116	22,813,784	-15,019,663	7,794,121	50.00
51.00	05100	RECOVERY ROOM	3,216,996	1,464,229	4,681,225	-246,191	4,435,034	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	627,836	22,865	650,701	3,480,349	4,131,050	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,092,582	1,958,972	4,051,554	-1,282,925	2,768,629	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	669,295	1,862,179	2,531,474	-1,360,183	1,171,291	55.00
57.00	05700	CT SCAN	834,807	1,214,741	2,049,548	-83,293	1,966,255	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	481,809	297,103	778,912	-7,904	771,008	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,454,470	8,659,013	10,113,483	-7,104,456	3,009,027	59.00
60.00	06000	LABORATORY	0	8,150,780	8,150,780	-2,184	8,148,596	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,347,291	1,204,268	3,551,559	-419,151	3,132,408	65.00
66.00	06600	PHYSICAL THERAPY	3,369,588	1,543,595	4,913,183	-1,565,301	3,347,882	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	890,148	890,148	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	192,031	192,031	68.00
69.00	06900	ELECTROCARDIOLOGY	1,145,073	628,121	1,773,194	-125,839	1,647,355	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	495,218	382,914	878,132	-114,770	763,362	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	520,807	1,567,818	2,088,625	11,882,996	13,971,621	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,718,482	9,718,482	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,230,228	9,458,633	12,688,861	-61,450	12,627,411	73.00
74.00	07400	RENAL DIALYSIS	0	557,886	557,886	-1,568	556,318	74.00
76.00	03950	ENDOSCOPY	708,952	1,142,520	1,851,472	-738,625	1,112,847	76.00
76.06	03330	IMAGING CENTER	982,838	1,036,483	2,019,321	-455,991	1,563,330	76.06
76.97	07697	CARDIAC REHABILITATION	346,356	131,545	477,901	-23,235	454,666	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	564,577	183,668	748,245	-13,993	734,252	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	226,699	161,058	387,757	-70,103	317,654	90.04
91.00	09100	EMERGENCY	5,744,876	3,985,053	9,729,929	-376,057	9,353,872	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,967,800	177,321,570	249,289,370	-7,303	249,282,067	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	111,520	111,520	0	111,520	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	679,384	682,629	1,362,013	7,303	1,369,316	194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	72,647,184	178,115,719	250,762,903	0	250,762,903	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0128

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

Worksheet A  
Date/Time Prepared:  
5/30/2022 2:34 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,673,609	7,601,050	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,572,482	9,307,313	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,573,039	3,573,067	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-36,321,839	42,200,532	5.00
7.00	00700	OPERATION OF PLANT	1,105,064	5,829,030	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	671,661	8.00
9.00	00900	HOUSEKEEPING	0	2,669,776	9.00
10.00	01000	DIETARY	-21,764	1,026,950	10.00
11.00	01100	CAFETERIA	-1,208,535	706,121	11.00
13.00	01300	NURSING ADMINISTRATION	2,206,328	2,642,607	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,517,927	1,517,927	16.00
17.00	01700	SOCIAL SERVICE	0	1,683,929	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	914,558	914,558	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,237,603	1,237,603	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-6,223,683	33,286,452	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,729,211	31.00
43.00	04300	NURSERY	0	783,201	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-44,800	7,749,321	50.00
51.00	05100	RECOVERY ROOM	0	4,435,034	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,131,050	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-311,994	2,456,635	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,171,291	55.00
57.00	05700	CT SCAN	0	1,966,255	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	771,008	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,009,027	59.00
60.00	06000	LABORATORY	0	8,148,596	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,132,408	65.00
66.00	06600	PHYSICAL THERAPY	-35,084	3,312,798	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	890,148	67.00
68.00	06800	SPEECH PATHOLOGY	0	192,031	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,647,355	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	157,992	921,354	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,175,479	15,147,100	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,718,482	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	125,507	12,752,918	73.00
74.00	07400	RENAL DIALYSIS	0	556,318	74.00
76.00	03950	ENDOSCOPY	0	1,112,847	76.00
76.06	03330	IMAGING CENTER	-93	1,563,237	76.06
76.97	07697	CARDIAC REHABILITATION	0	454,666	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	-334,219	400,033	90.02
90.03	04952	PALLIATIVE CARE	0	0	90.03
90.04	04953	SPIRE CENTER	0	317,654	90.04
91.00	09100	EMERGENCY	599,291	9,953,163	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-32,990,350	216,291,717	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	111,520	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	HOME OFFICE	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	0	1,369,316	194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	-32,990,350	217,772,553	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
<b>A - Chargeable Medical Supplies</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	13,116,310		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
<b>TOTALS</b>			0	13,116,310		
<b>B - Implantable Device Recl ass</b>						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,718,482		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
<b>TOTALS</b>			0	9,718,482		
<b>C - Drugs Charges to Pat</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,518		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	21,002		2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	502,358		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
<b>TOTALS</b>			0	531,878		
<b>D - Depreciation Expense</b>						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,292,649		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00

RECLASSIFICATIONS

Provider CCN: 15-0128

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

Worksheet A-6  
Date/Time Prepared:  
5/30/2022 2:34 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
	TOTALS		0	9,292,649	
<b>E - Interest Expense</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,094,102	1.00
	TOTALS		0	5,094,102	
<b>F - Other Capital Rental</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,419,862	1.00
2.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	17,000	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	TOTALS		0	3,436,862	
<b>G - STD BENEFIT</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,041	1.00
2.00	OPERATION OF PLANT	7.00	0	2,523	2.00
3.00	HOUSEKEEPING	9.00	0	2,958	3.00
4.00	DIETARY	10.00	0	6,348	4.00
5.00	NURSING ADMINISTRATION	13.00	0	752	5.00
6.00	SOCIAL SERVICE	17.00	0	2,240	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	153,252	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	41,970	8.00
9.00	OPERATING ROOM	50.00	0	19,546	9.00
10.00	RECOVERY ROOM	51.00	0	6,952	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	18,194	11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	3,222	12.00
13.00	CT SCAN	57.00	0	4,269	13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	454	14.00
15.00	RESPIRATORY THERAPY	65.00	0	15,827	15.00
16.00	PHYSICAL THERAPY	66.00	0	8,466	16.00
17.00	ELECTROCARDIOLOGY	69.00	0	5,359	17.00
18.00	DRUGS CHARGED TO PATIENTS	73.00	0	13,521	18.00
19.00	IMAGING CENTER	76.06	0	3,475	19.00
20.00	ANTI-COAGULATION CLINIC	90.02	0	6,439	20.00
21.00	EMERGENCY	91.00	0	17,566	21.00
22.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	4,923	22.00
	TOTALS		0	353,297	
<b>H - Labor and Delivery</b>					
1.00	NURSERY	43.00	563,425	219,776	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	2,503,718	976,631	2.00
	TOTALS		3,067,143	1,196,407	
<b>I - Cafeteria</b>					
1.00	CAFETERIA	11.00	889,585	1,025,071	1.00
	TOTALS		889,585	1,025,071	
<b>J - Therapy</b>					
1.00	OCCUPATIONAL THERAPY	67.00	676,451	213,697	1.00
2.00	SPEECH PATHOLOGY	68.00	145,930	46,101	2.00
	TOTALS		822,381	259,798	



Provider CCN: 15-0128

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

Worksheet A-6  
Date/Time Prepared:  
5/30/2022 2:34 pm

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
K - Building Depreciation					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,977,680	1.00
	TOTALS		0	4,977,680	
L - Capital Insurance Costs					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	202,877	1.00
	TOTALS		0	202,877	
M - Radiology Support Staff					
1.00	RADIOLOGY-THERAPEUTIC	55.00	64,847	50,180	1.00
2.00	CT SCAN	57.00	160,864	124,483	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	33,429	25,869	3.00
	TOTALS		259,140	200,532	
500.00	Grand Total: Increases		5,038,249	49,405,945	500.00

RECLASSIFICATIONS

Provider CCN: 15-0128

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

Worksheet A-6  
Date/Time Prepared:  
5/30/2022 2:34 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
<b>A - Chargeable Medical Supplies</b>							
1.00	DIETARY	10.00	0	198	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,135,375	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	274,599	0		3.00
4.00	OPERATING ROOM	50.00	0	5,793,047	0		4.00
5.00	RECOVERY ROOM	51.00	0	189,669	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	425,202	0		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	910,375	0		7.00
8.00	CT SCAN	57.00	0	106,839	0		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	13,133	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	3,040,893	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	391,039	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	2,698	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	9,152	0		13.00
14.00	ELECTROENCEPHALOGRAPHY	70.00	0	7,271	0		14.00
15.00	DRUGS CHARGED TO PATIENTS	73.00	0	57,789	0		15.00
16.00	RENAL DIALYSIS	74.00	0	1,049	0		16.00
17.00	ENDOSCOPY	76.00	0	488,270	0		17.00
18.00	IMAGING CENTER	76.06	0	34,876	0		18.00
19.00	CARDIAC REHABILITATION	76.97	0	2,557	0		19.00
20.00	EMERGENCY	91.00	0	232,279	0		20.00
TOTALS			0	13,116,310			
<b>B - Implantable Device Recl ass</b>							
1.00	OPERATING ROOM	50.00	0	6,079,627	0		1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00	0	313,118	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	3,325,476	0		3.00
4.00	ENDOSCOPY	76.00	0	261	0		4.00
TOTALS			0	9,718,482			
<b>C - Drugs Charges to Pat</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	44,542	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	8,912	0		2.00
3.00	OPERATING ROOM	50.00	0	4,470	0		3.00
4.00	RECOVERY ROOM	51.00	0	10,328	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	115,199	0		5.00
6.00	RADIOLOGY-THERAPEUTIC	55.00	0	58	0		6.00
7.00	CT SCAN	57.00	0	203,279	0		7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	6,651	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	61,637	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	326	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	1,007	0		11.00
12.00	ELECTROENCEPHALOGRAPHY	70.00	0	270	0		12.00
13.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	21,669	0		13.00
14.00	RENAL DIALYSIS	74.00	0	519	0		14.00
15.00	ENDOSCOPY	76.00	0	341	0		15.00
16.00	IMAGING CENTER	76.06	0	29,735	0		16.00
17.00	ANTI-COAGULATION CLINIC	90.02	0	71	0		17.00
18.00	EMERGENCY	91.00	0	17,465	0		18.00
19.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	5,399	0		19.00
TOTALS			0	531,878			
<b>D - Depreciation Expense</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,907,935	9		1.00
2.00	OPERATION OF PLANT	7.00	0	126,063	0		2.00
3.00	HOUSEKEEPING	9.00	0	4,226	0		3.00
4.00	DIETARY	10.00	0	27,780	0		4.00
5.00	SOCIAL SERVICE	17.00	0	1,805	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	362,222	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	177,012	0		7.00
8.00	OPERATING ROOM	50.00	0	2,396,879	0		8.00
9.00	RECOVERY ROOM	51.00	0	42,270	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	282,852	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	251,545	0		11.00
12.00	CT SCAN	57.00	0	20,602	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	47,418	0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	675,038	0		14.00
15.00	LABORATORY	60.00	0	2,173	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	27,653	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	112,687	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	137,584	0		18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	7,548	0		19.00

RECLASSIFICATIONS

Provider CCN: 15-0128

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

Worksheet A-6  
Date/Time Prepared:  
5/30/2022 2:34 pm

Decreases							
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
6.00	7.00	8.00	9.00	10.00			
20.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	32,106	0	20.00	
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	70,702	0	21.00	
22.00	ENDOSCOPY	76.00	0	249,284	0	22.00	
23.00	IMAGING CENTER	76.06	0	149,979	0	23.00	
24.00	CARDIAC REHABILITATION	76.97	0	20,678	0	24.00	
25.00	ANTI-COAGULATION CLINIC	90.02	0	13,922	0	25.00	
26.00	SPINE CENTER	90.04	0	14,082	0	26.00	
27.00	EMERGENCY	91.00	0	126,306	0	27.00	
28.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	4,298	0	28.00	
	TOTALS		0	9,292,649			
<b>E - Interest Expense</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,094,102	11	1.00	
	TOTALS		0	5,094,102			
<b>F - Other Capital Rental</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	203,339	10	1.00	
2.00	OPERATION OF PLANT	7.00	0	5,394	0	2.00	
3.00	HOUSEKEEPING	9.00	0	8,959	0	3.00	
4.00	DIETARY	10.00	0	106	0	4.00	
5.00	SOCIAL SERVICE	17.00	0	33	0	5.00	
6.00	ADULTS & PEDIATRICS	30.00	0	50,607	0	6.00	
7.00	OPERATING ROOM	50.00	0	745,640	0	7.00	
8.00	RECOVERY ROOM	51.00	0	3,924	0	8.00	
9.00	RADIOLOGY-THERAPEUTIC	55.00	0	114	0	9.00	
10.00	CT SCAN	57.00	0	37,920	0	10.00	
11.00	CARDIAC CATHETERIZATION	59.00	0	1,412	0	11.00	
12.00	LABORATORY	60.00	0	11	0	12.00	
13.00	RESPIRATORY THERAPY	65.00	0	133	0	13.00	
14.00	PHYSICAL THERAPY	66.00	0	366,730	0	14.00	
15.00	ELECTROCARDIOLOGY	69.00	0	105	0	15.00	
16.00	ELECTROENCEPHALOGRAPHY	70.00	0	99,681	0	16.00	
17.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,179,539	0	17.00	
18.00	DRUGS CHARGED TO PATIENTS	73.00	0	435,317	0	18.00	
19.00	ENDOSCOPY	76.00	0	469	0	19.00	
20.00	IMAGING CENTER	76.06	0	241,401	0	20.00	
21.00	SPINE CENTER	90.04	0	56,021	0	21.00	
22.00	EMERGENCY	91.00	0	7	0	22.00	
	TOTALS		0	3,436,862			
<b>G - STD BENEFIT</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	15,041	0	0	1.00	
2.00	OPERATION OF PLANT	7.00	2,523	0	0	2.00	
3.00	HOUSEKEEPING	9.00	2,958	0	0	3.00	
4.00	DIETARY	10.00	6,348	0	0	4.00	
5.00	NURSING ADMINISTRATION	13.00	752	0	0	5.00	
6.00	SOCIAL SERVICE	17.00	2,240	0	0	6.00	
7.00	ADULTS & PEDIATRICS	30.00	153,252	0	0	7.00	
8.00	INTENSIVE CARE UNIT	31.00	41,970	0	0	8.00	
9.00	OPERATING ROOM	50.00	19,546	0	0	9.00	
10.00	RECOVERY ROOM	51.00	6,952	0	0	10.00	
11.00	RADIOLOGY-DIAGNOSTIC	54.00	18,194	0	0	11.00	
12.00	RADIOLOGY-THERAPEUTIC	55.00	3,222	0	0	12.00	
13.00	CT SCAN	57.00	4,269	0	0	13.00	
14.00	CARDIAC CATHETERIZATION	59.00	454	0	0	14.00	
15.00	RESPIRATORY THERAPY	65.00	15,827	0	0	15.00	
16.00	PHYSICAL THERAPY	66.00	8,466	0	0	16.00	
17.00	ELECTROCARDIOLOGY	69.00	5,359	0	0	17.00	
18.00	DRUGS CHARGED TO PATIENTS	73.00	13,521	0	0	18.00	
19.00	IMAGING CENTER	76.06	3,475	0	0	19.00	
20.00	ANTI-COAGULATION CLINIC	90.02	6,439	0	0	20.00	
21.00	EMERGENCY	91.00	17,566	0	0	21.00	
22.00	MISC NONREIMBURSABLE COST CENTERS	194.08	4,923	0	0	22.00	
	TOTALS		353,297	0	0		
<b>H - Labor and Delivery</b>							
1.00	ADULTS & PEDIATRICS	30.00	3,067,143	1,196,407	0	1.00	
2.00		0.00	0	0	0	2.00	
	TOTALS		3,067,143	1,196,407			
<b>I - Cafeteria</b>							
1.00	DIETARY	10.00	889,585	1,025,071	0	1.00	
	TOTALS		889,585	1,025,071			

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>J - Therapy</b>							
1.00	PHYSICAL THERAPY	66.00	822,381	259,798	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		822,381	259,798			
<b>K - Building Depreciation</b>							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,977,680	9		1.00
	TOTALS		0	4,977,680			
<b>L - Capital Insurance Costs</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	202,877	12		1.00
	TOTALS		0	202,877			
<b>M - Radiology Support Staff</b>							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	259,140	200,532	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		259,140	200,532			
500.00	Grand Total: Decreases		5,391,546	49,052,648			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0128

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/30/2022 2:34 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	1,821,632	0	0	0	1.00
2.00	Land Improvements	2,722,362	139,620	0	139,620	2.00
3.00	Buildings and Fixtures	185,616,539	5,527,984	0	5,527,984	3.00
4.00	Building Improvements	1,737,035	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	84,055,268	3,075,097	0	3,075,097	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	275,952,836	8,742,701	0	8,742,701	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	275,952,836	8,742,701	0	8,742,701	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	1,821,632	0			1.00
2.00	Land Improvements	3,022,362	0			2.00
3.00	Buildings and Fixtures	190,935,678	0			3.00
4.00	Building Improvements	1,737,035	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	86,291,407	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	283,808,114	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	283,808,114	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0128

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/30/2022 2:34 pm

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0128

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/30/2022 2:34 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	197,516,707	0	197,516,707	0.695952	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	86,291,407	0	86,291,407	0.304048	0	2.00
3.00	Total (sum of lines 1-2)	283,808,114	0	283,808,114	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	4,977,680	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,887,451	3,419,862	2.00
3.00	Total (sum of lines 1-2)	0	0	0	10,865,131	3,419,862	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	2,420,493	202,877	0	0	7,601,050	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	9,307,313	2.00
3.00	Total (sum of lines 1-2)	2,420,493	202,877	0	0	16,908,363	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0128

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

Worksheet A-8

Date/Time Prepared:  
5/30/2022 2:34 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)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)	B	-1,174	0	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0	0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0	0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0	0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0	0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0	0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0	0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-682,930	0			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0	0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	9,546,876	0			0	12.00
13.00 Laundry and linen service		0	0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-1,119,305	0	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others		0	0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0	0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0	0		0.00	0	17.00
18.00 Sale of medical records and abstracts		0	0		0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0	0		0.00	0	19.00
20.00 Vending machines		0	0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0	0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0	0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0	0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0	0		0.00	0	32.00
33.00 Loss on Assets	A	0	0	OPERATING ROOM	50.00	0	33.00



ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0128

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

Worksheet A-8

Date/Time Prepared:  
5/30/2022 2:34 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
33.01 Misc Revenue	B		ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 Misc Revenue	B		OPERATION OF PLANT	7.00	0	33.02
33.03 Misc Revenue	B		DIETARY	10.00	0	33.03
33.04 Misc Revenue	B		OPERATING ROOM	50.00	0	33.04
33.05 Misc Revenue	B		RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06 Misc Revenue	B		PHYSICAL THERAPY	66.00	0	33.06
33.07 Misc Revenue	B		MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.07
33.08 Misc Revenue	B		DRUGS CHARGED TO PATIENTS	73.00	0	33.08
33.09 Misc Revenue	B		IMAGING CENTER	76.06	0	33.09
33.10 Misc Revenue	B		CARDIAC REHABILITATION	76.97	0	33.10
33.11 Purchased Discounts	B		ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12 Space Rental Income	B		OPERATION OF PLANT	7.00	0	33.12
33.13 Investment Income	B		ADMINISTRATIVE & GENERAL	5.00	0	33.13
34.00 HAF Tax Offset	A	-16,209,505	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01 LOC Non-Allow Interest Expense	A	-28,604	CAP REL COSTS-BLDG & FIXT	1.00	11	34.01
34.02 Non-Allowable Interest Expense	A	-35,568	CAP REL COSTS-BLDG & FIXT	1.00	11	34.02
34.03 2012B Non-Allow Interest Expense	A	-26,248	CAP REL COSTS-BLDG & FIXT	1.00	11	34.03
34.05 12B Non-Allow Interest Expense	A	-105,480	CAP REL COSTS-BLDG & FIXT	1.00	11	34.05
34.06 50 BMO Loan Non-Allow Interest Expense	A	-33,906	ADMINISTRATIVE & GENERAL	5.00	0	34.06
34.07 Non-Allowable Interest Expense	A	-1,453,857	CAP REL COSTS-BLDG & FIXT	1.00	11	34.07
34.08 00 Non-Allow Interest Expense	A	-1,023,852	CAP REL COSTS-BLDG & FIXT	1.00	11	34.08
36.00 Meals on Wheels Cost	A	-89,230	CAFETERIA	11.00	0	36.00
36.01 Bad Debt	A	-13,355,134	ADMINISTRATIVE & GENERAL	5.00	0	36.01
36.02 APP	A	-334,219	ANTI-COAGULATION CLINIC	90.02	0	36.02
36.03 Misc Revenue	B	-440,147	ADMINISTRATIVE & GENERAL	5.00	0	36.03
36.04 Misc Revenue	B	-3,000	OPERATION OF PLANT	7.00	0	36.04
36.05 Misc Revenue	B	-21,764	DIETARY	10.00	0	36.05
36.06 Misc Revenue	B	-437,216	RADIOLOGY-DIAGNOSTIC	54.00	0	36.06
36.07 Misc Revenue	B	-35,084	PHYSICAL THERAPY	66.00	0	36.07
36.08 Misc Revenue	B	-8,224	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	36.08
36.09 Misc Revenue	B	-46,800	DRUGS CHARGED TO PATIENTS	73.00	0	36.09
36.10 Misc Revenue	B	-93	IMAGING CENTER	76.06	0	36.10
36.11 Space Rental Income	B	-747,893	OPERATION OF PLANT	7.00	0	36.11
36.12 Hospitalist Loss	A	-6,297,993	ADULTS & PEDIATRICS	30.00	0	36.12
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-32,990,350				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: 15-0128  
 Period: From 01/01/2021 To 12/31/2021  
 Worksheet A-8-1  
 Date/Time Prepared: 5/30/2022 2:34 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	21.00	I&R SERVICES-SALARY & FRINGE	RESIDENTS	914,558	0 1.00
2.00	22.00	I&R SERVICES-OTHER PRGM. COS	RESIDENTS	1,237,603	0 2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	1,572,482	0 3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	3,573,039	0 3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	34,846,473	40,497,910 3.02
3.03	7.00	OPERATION OF PLANT	HOME OFFICE	1,855,957	0 3.03
3.04	13.00	NURSING ADMINISTRATION	HOME OFFICE	2,206,328	0 3.04
3.05	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	1,183,703	0 3.05
3.06	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	1,517,927	0 3.06
3.07	30.00	ADULTS & PEDIATRICS	HOME OFFICE	74,310	0 3.07
3.08	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	125,222	0 3.08
3.09	70.00	ELECTROENCEPHALOGRAPHY	HOME OFFICE	157,992	0 3.09
3.10	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	172,307	0 3.10
4.00	5.00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR	7,594	0 4.00
4.01	91.00	EMERGENCY	CPN ON CALL	599,291	0 4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			50,044,786	40,497,910 5.00

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

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

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

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

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

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

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

Provider CCN: 15-0128

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

Worksheet A-8-1

Date/Time Prepared:  
5/30/2022 2:34 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	914,558	0		1.00
2.00	1,237,603	0		2.00
3.00	1,572,482	9		3.00
3.01	3,573,039	0		3.01
3.02	-5,651,437	0		3.02
3.03	1,855,957	0		3.03
3.04	2,206,328	0		3.04
3.05	1,183,703	0		3.05
3.06	1,517,927	0		3.06
3.07	74,310	0		3.07
3.08	125,222	0		3.08
3.09	157,992	0		3.09
3.10	172,307	0		3.10
4.00	7,594	0		4.00
4.01	599,291	0		4.01
5.00	9,546,876			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0128

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

Worksheet A-8-2

Date/Time Prepared:  
5/30/2022 2:34 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	638,130	638,130	0	0	0	1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	44,800	44,800	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			682,930	682,930	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	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	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	638,130		1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	44,800		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	682,930		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2022 2:34 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	7,601,050	7,601,050			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	9,307,313		9,307,313		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,573,067	0	0	3,573,067	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	42,200,532	393,149	2,351,014	220,741	45,165,436
7.00 00700	OPERATION OF PLANT	5,829,030	1,400,592	51,349	41,555	7,322,526
8.00 00800	LAUNDRY & LINEN SERVICE	671,661	20,644	0	0	692,305
9.00 00900	HOUSEKEEPING	2,669,776	43,845	13,010	77,181	2,803,812
10.00 01000	DIETARY	1,026,950	87,137	7,307	23,773	1,145,167
11.00 01100	CAFETERIA	706,121	159,052	17,641	43,967	926,781
13.00 01300	NURSING ADMINISTRATION	2,642,607	0	0	17,354	2,659,961
16.00 01600	MEDICAL RECORDS & LIBRARY	1,517,927	0	0	0	1,517,927
17.00 01700	SOCIAL SERVICE	1,683,929	20,378	1,814	64,932	1,771,053
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	914,558	0	0	0	914,558
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,237,603	11,662	0	0	1,249,265
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	33,286,452	1,829,993	199,243	1,103,114	36,418,802
31.00 03100	INTENSIVE CARE UNIT	4,729,211	554,144	174,658	172,705	5,630,718
43.00 04300	NURSERY	783,201	49,389	9,604	27,847	870,041
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	7,749,321	775,638	2,119,917	191,672	10,836,548
51.00 05100	RECOVERY ROOM	4,435,034	160,504	45,043	158,653	4,799,234
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,131,050	219,448	42,676	154,774	4,547,948
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,456,635	263,170	245,955	89,717	3,055,477
55.00 05500	RADIOLOGY-THERAPEUTIC	1,171,291	0	246,590	36,125	1,454,006
57.00 05700	CT SCAN	1,966,255	34,842	40,093	48,999	2,090,189
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	771,008	31,794	15,347	25,465	843,614
59.00 05900	CARDIAC CATHETERIZATION	3,009,027	209,750	440,755	71,863	3,731,395
60.00 06000	LABORATORY	8,148,596	97,162	11	0	8,245,769
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	3,132,408	48,202	25,461	115,230	3,321,301
66.00 06600	PHYSICAL THERAPY	3,312,798	16,286	557,092	125,475	4,011,651
67.00 06700	OCCUPATIONAL THERAPY	890,148	4,317	22,321	33,433	950,219
68.00 06800	SPEECH PATHOLOGY	192,031	941	4,815	7,212	204,999
69.00 06900	ELECTROCARDIOLOGY	1,647,355	114,082	109,430	56,329	1,927,196
70.00 07000	ELECTROENCEPHALOGRAPHY	921,354	47,220	105,804	24,476	1,098,854
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,147,100	219,755	1,195,505	25,740	16,588,100
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	9,718,482	0	0	0	9,718,482
73.00 07300	DRUGS CHARGED TO PATIENTS	12,752,918	119,545	481,763	158,983	13,513,209
74.00 07400	RENAL DIALYSIS	556,318	22,014	0	0	578,332
76.00 03950	ENDOSCOPY	1,112,847	0	204,622	35,039	1,352,508
76.06 03330	IMAGING CENTER	1,563,237	0	386,174	48,404	1,997,815
76.97 07697	CARDIAC REHABILITATION	454,666	0	15,285	17,118	487,069
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	0
90.02 04951	ANTI-COAGULATION CLINIC	400,033	0	710	27,585	428,328
90.03 04952	PALLIATIVE CARE	0	0	0	0	0
90.04 04953	SPINE CENTER	317,654	0	69,086	11,204	397,944
91.00 09100	EMERGENCY	9,953,163	635,306	107,140	283,067	10,978,676
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	216,291,717	7,589,961	9,307,235	3,539,732	216,247,215
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	111,520	0	0	0	111,520
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	HOME OFFICE	0	0	0	0	0
194.06 07956	LEASED OFFICE SPACE	0	0	0	0	0
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	1,369,316	11,089	78	33,335	1,413,818
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	217,772,553	7,601,050	9,307,313	3,573,067	217,772,553

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/30/2022 2:34 pm
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	45,165,436				5.00
7.00	00700	OPERATION OF PLANT	1,916,056	9,238,582			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	181,153	32,841	906,299		8.00
9.00	00900	HOUSEKEEPING	733,662	69,750	0	3,607,224	9.00
10.00	01000	DIETARY	299,651	138,622	0	54,733	1,638,173
11.00	01100	CAFETERIA	242,507	253,028	0	99,905	0
13.00	01300	NURSING ADMINISTRATION	696,021	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	397,190	0	0	0	0
17.00	01700	SOCIAL SERVICE	463,424	32,418	0	12,800	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	239,309	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	326,890	18,552	0	7,325	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	9,529,589	2,911,252	423,425	1,149,471	1,500,082
31.00	03100	INTENSIVE CARE UNIT	1,473,367	881,562	44,346	348,073	138,091
43.00	04300	NURSERY	227,660	78,571	7,813	31,023	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	2,835,556	1,233,927	0	487,199	0
51.00	05100	RECOVERY ROOM	1,255,796	255,339	138,108	100,817	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,190,043	349,110	34,727	137,841	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	799,514	418,665	14,973	165,304	0
55.00	05500	RADIOLOGY-THERAPEUTIC	380,464	0	12,675	0	0
57.00	05700	CT SCAN	546,931	55,429	59,719	21,885	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	220,745	50,580	0	19,971	0
59.00	05900	CARDIAC CATHETERIZATION	976,379	333,682	0	131,750	0
60.00	06000	LABORATORY	2,157,637	154,570	0	61,030	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	869,072	76,683	0	30,277	0
66.00	06600	PHYSICAL THERAPY	1,049,713	25,908	0	10,230	0
67.00	06700	OCCUPATIONAL THERAPY	248,640	6,868	0	2,712	0
68.00	06800	SPEECH PATHOLOGY	53,641	1,497	0	591	0
69.00	06900	ELECTROCARDIOLOGY	504,282	181,488	0	71,658	0
70.00	07000	ELECTROENCEPHALOGRAPHY	287,533	75,121	0	29,660	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,340,542	349,598	0	138,034	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,542,996	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,535,947	190,178	0	75,089	0
74.00	07400	RENAL DIALYSIS	151,330	35,022	0	13,828	0
76.00	03950	ENDOSCOPY	353,905	0	0	0	0
76.06	03330	IMAGING CENTER	522,760	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	127,449	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0
90.02	04951	ANTI-COAGULATION CLINIC	112,079	0	0	0	0
90.03	04952	PALLIATIVE CARE	0	0	0	0	0
90.04	04953	SPINE CENTER	104,128	0	0	0	0
91.00	09100	EMERGENCY	2,872,746	1,010,680	170,513	399,053	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,766,307	9,220,941	906,299	3,600,259	1,638,173
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29,181	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	HOME OFFICE	0	0	0	0	0
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	0
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	369,948	17,641	0	6,965	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	45,165,436	9,238,582	906,299	3,607,224	1,638,173

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2022 2:34 pm

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS	SERVICES-SALARY & FRINGES	
	11.00	13.00	16.00	17.00	21.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 CAP REL COSTS-BLDG & FIXT							1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP							2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT							4.00
5.00 00500 ADMINISTRATIVE & GENERAL							5.00
7.00 00700 OPERATION OF PLANT							7.00
8.00 00800 LAUNDRY & LINEN SERVICE							8.00
9.00 00900 HOUSEKEEPING							9.00
10.00 01000 DIETARY							10.00
11.00 01100 CAFETERIA	1,522,221						11.00
13.00 01300 NURSING ADMINISTRATION	19,405	3,375,387					13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	1,915,117				16.00
17.00 01700 SOCIAL SERVICE	32,342	0	0	2,312,037			17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	1,153,867		21.00
22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0		22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	575,682	2,390,526	232,697	2,001,374	831,647		30.00
31.00 03100 INTENSIVE CARE UNIT	68,996	286,505	24,365	169,294	67,050		31.00
43.00 04300 NURSERY	12,937	53,720	7,282	141,369	0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	109,962	0	235,666	0	55,090		50.00
51.00 05100 RECOVERY ROOM	73,308	0	65,602	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	58,215	0	32,360	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	49,591	0	69,621	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	17,249	0	45,553	0	0		55.00
57.00 05700 CT SCAN	28,030	0	130,482	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	15,093	0	26,787	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	32,342	0	193,599	0	0		59.00
60.00 06000 LABORATORY	0	0	147,512	0	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	51,747	0	36,728	0	0		65.00
66.00 06600 PHYSICAL THERAPY	28,030	0	19,815	0	32,983		66.00
67.00 06700 OCCUPATIONAL THERAPY	17,249	0	5,431	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	4,312	0	1,171	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	40,966	0	47,885	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	12,937	0	10,337	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21,561	0	59,712	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	62,554	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	68,996	0	118,770	0	0		73.00
74.00 07400 RENAL DIALYSIS	0	0	4,138	0	0		74.00
76.00 03950 ENDOSCOPY	15,093	0	19,288	0	0		76.00
76.06 03330 IMAGING CENTER	0	0	32,278	0	0		76.06
76.97 07697 CARDIAC REHABILITATION	12,937	0	3,629	0	0		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0	0	0	0		90.00
90.01 04950 DIABETIC CARE CENTER	0	0	0	0	0		90.01
90.02 04951 ANTI-COAGULATION CLINIC	0	0	2,179	0	0		90.02
90.03 04952 PALLIATIVE CARE	0	0	0	0	0		90.03
90.04 04953 SPINE CENTER	0	0	780	0	0		90.04
91.00 09100 EMERGENCY	155,241	644,636	278,896	0	132,659		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,522,221	3,375,387	1,915,117	2,312,037	1,119,429	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0		190.00
191.00 19100 RESEARCH	0	0	0	0	0		191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	12,688		192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0		193.00
194.00 07950 HOME OFFICE	0	0	0	0	0		194.00
194.06 07956 LEASED OFFICE SPACE	0	0	0	0	0		194.06
194.08 07958 MISC NONREIMBURSABLE COST CENTERS	0	0	0	0	21,750		194.08
200.00	Cross Foot Adjustments	0	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	1,522,221	3,375,387	1,915,117	2,312,037	1,153,867	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2022 2:34 pm

Cost Center Description	INTERNS & RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	SERVICES-OTHER PRGM. COSTS					
	22.00	24.00	25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
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	
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00 01700	SOCIAL SERVICE				17.00	
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00	
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,602,032			22.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	1,154,660	59,119,207	-1,986,307	57,132,900	30.00
31.00 03100	INTENSIVE CARE UNIT	93,093	9,225,460	-160,143	9,065,317	31.00
43.00 04300	NURSERY	0	1,430,416	0	1,430,416	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	76,488	15,870,436	-131,578	15,738,858	50.00
51.00 05100	RECOVERY ROOM	0	6,688,204	0	6,688,204	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	6,350,244	0	6,350,244	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	4,573,145	0	4,573,145	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	1,909,947	0	1,909,947	55.00
57.00 05700	CT SCAN	0	2,932,665	0	2,932,665	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,176,790	0	1,176,790	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	5,399,147	0	5,399,147	59.00
60.00 06000	LABORATORY	0	10,766,518	0	10,766,518	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	4,385,808	0	4,385,808	65.00
66.00 06600	PHYSICAL THERAPY	45,793	5,224,123	-78,776	5,145,347	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	1,231,119	0	1,231,119	67.00
68.00 06800	SPEECH PATHOLOGY	0	266,211	0	266,211	68.00
69.00 06900	ELECTROCARDIOLOGY	0	2,773,475	0	2,773,475	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	1,514,442	0	1,514,442	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,497,547	0	21,497,547	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,324,032	0	12,324,032	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	17,502,189	0	17,502,189	73.00
74.00 07400	RENAL DIALYSIS	0	782,650	0	782,650	74.00
76.00 03950	ENDOSCOPY	0	1,740,794	0	1,740,794	76.00
76.06 03330	IMAGING CENTER	0	2,552,853	0	2,552,853	76.06
76.97 07697	CARDIAC REHABILITATION	0	631,084	0	631,084	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	90.01
90.02 04951	ANTI-COAGULATION CLINIC	0	542,586	0	542,586	90.02
90.03 04952	PALLIATIVE CARE	0	0	0	0	90.03
90.04 04953	SPINE CENTER	0	502,852	0	502,852	90.04
91.00 09100	EMERGENCY	184,184	16,827,284	-316,843	16,510,441	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,554,218	215,741,228	-2,673,647	213,067,581	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	17,616	171,005	-30,304	140,701	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00
194.06 07956	LEASED OFFICE SPACE	0	0	0	0	194.06
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	30,198	1,860,320	-51,948	1,808,372	194.08
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,602,032	217,772,553	-2,755,899	215,016,654	202.00



ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0128

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2022 2:34 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	393,149	2,351,014	2,744,163	5.00
7.00 00700	OPERATION OF PLANT	0	1,400,592	51,349	1,451,941	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	20,644	0	20,644	8.00
9.00 00900	HOUSEKEEPING	0	43,845	13,010	56,855	9.00
10.00 01000	DIETARY	0	87,137	7,307	94,444	10.00
11.00 01100	CAFETERIA	0	159,052	17,641	176,693	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	20,378	1,814	22,192	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	11,662	0	11,662	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	1,829,993	199,243	2,029,236	30.00
31.00 03100	INTENSIVE CARE UNIT	0	554,144	174,658	728,802	31.00
43.00 04300	NURSERY	0	49,389	9,604	58,993	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	775,638	2,119,917	2,895,555	50.00
51.00 05100	RECOVERY ROOM	0	160,504	45,043	205,547	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	219,448	42,676	262,124	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	263,170	245,955	509,125	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	246,590	246,590	55.00
57.00 05700	CT SCAN	0	34,842	40,093	74,935	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	31,794	15,347	47,141	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	209,750	440,755	650,505	59.00
60.00 06000	LABORATORY	0	97,162	11	97,173	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	48,202	25,461	73,663	65.00
66.00 06600	PHYSICAL THERAPY	0	16,286	557,092	573,378	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	4,317	22,321	26,638	67.00
68.00 06800	SPEECH PATHOLOGY	0	941	4,815	5,756	68.00
69.00 06900	ELECTROCARDIOLOGY	0	114,082	109,430	223,512	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	47,220	105,804	153,024	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	219,755	1,195,505	1,415,260	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	119,545	481,763	601,308	73.00
74.00 07400	RENAL DIALYSIS	0	22,014	0	22,014	74.00
76.00 03950	ENDOSCOPY	0	0	204,622	204,622	76.00
76.06 03330	IMAGING CENTER	0	0	386,174	386,174	76.06
76.97 07697	CARDIAC REHABILITATION	0	0	15,285	15,285	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	90.01
90.02 04951	ANTI-COAGULATION CLINIC	0	0	710	710	90.02
90.03 04952	PALLIATIVE CARE	0	0	0	0	90.03
90.04 04953	SPINE CENTER	0	0	69,086	69,086	90.04
91.00 09100	EMERGENCY	0	635,306	107,140	742,446	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	7,589,961	9,307,235	16,897,196	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00
194.06 07956	LEASED OFFICE SPACE	0	0	0	0	194.06
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	0	11,089	78	11,167	194.08
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	7,601,050	9,307,313	16,908,363	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0128		Period: From 01/01/2021 To 12/31/2021		Worksheet B Part II Date/Time Prepared: 5/30/2022 2:34 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,744,163				5.00
7.00	00700	OPERATION OF PLANT	116,414	1,568,355			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,006	5,575	37,225		8.00
9.00	00900	HOUSEKEEPING	44,575	11,841	0	113,271	9.00
10.00	01000	DIETARY	18,206	23,533	0	1,719	137,902
11.00	01100	CAFETERIA	14,734	42,954	0	3,137	0
13.00	01300	NURSING ADMINISTRATION	42,288	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	24,132	0	0	0	0
17.00	01700	SOCIAL SERVICE	28,156	5,503	0	402	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	14,540	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	19,861	3,149	0	230	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	579,040	494,221	17,391	36,095	126,277
31.00	03100	INTENSIVE CARE UNIT	89,517	149,655	1,821	10,930	11,625
43.00	04300	NURSERY	13,832	13,338	321	974	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	172,279	209,473	0	15,299	0
51.00	05100	RECOVERY ROOM	76,298	43,347	5,673	3,166	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	72,303	59,265	1,426	4,328	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,576	71,073	615	5,191	0
55.00	05500	RADIOLOGY-THERAPEUTIC	23,116	0	521	0	0
57.00	05700	CT SCAN	33,230	9,410	2,453	687	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,412	8,586	0	627	0
59.00	05900	CARDIAC CATHETERIZATION	59,322	56,646	0	4,137	0
60.00	06000	LABORATORY	131,091	26,240	0	1,916	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	52,802	13,018	0	951	0
66.00	06600	PHYSICAL THERAPY	63,777	4,398	0	321	0
67.00	06700	OCCUPATIONAL THERAPY	15,107	1,166	0	85	0
68.00	06800	SPEECH PATHOLOGY	3,259	254	0	19	0
69.00	06900	ELECTROCARDIOLOGY	30,639	30,810	0	2,250	0
70.00	07000	ELECTROENCEPHALOGRAPHY	17,470	12,753	0	931	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	263,718	59,348	0	4,334	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	154,504	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	214,833	32,285	0	2,358	0
74.00	07400	RENAL DIALYSIS	9,194	5,945	0	434	0
76.00	03950	ENDOSCOPY	21,502	0	0	0	0
76.06	03330	IMAGING CENTER	31,761	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	7,743	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0
90.02	04951	ANTI-COAGULATION CLINIC	6,810	0	0	0	0
90.03	04952	PALLIATIVE CARE	0	0	0	0	0
90.04	04953	SPINE CENTER	6,327	0	0	0	0
91.00	09100	EMERGENCY	174,539	171,574	7,004	12,531	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,719,913	1,565,360	37,225	113,052	137,902
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,773	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	HOME OFFICE	0	0	0	0	0
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	0
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	22,477	2,995	0	219	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	2,744,163	1,568,355	37,225	113,271	137,902

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/30/2022 2:34 pm		
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES
		11.00	13.00	16.00	17.00	21.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100	237,518				11.00
13.00	01300	3,028	45,316			13.00
16.00	01600	0	0	24,132		16.00
17.00	01700	5,046	0	0	61,299	17.00
21.00	02100	0	0	0	0	21.00
22.00	02200	0	0	0	0	14,540
22.00	02200	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	89,824	32,094	2,944	53,063	30.00
31.00	03100	10,766	3,846	308	4,488	31.00
43.00	04300	2,019	721	92	3,748	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	17,158	0	2,981	0	50.00
51.00	05100	11,439	0	830	0	51.00
52.00	05200	9,084	0	409	0	52.00
54.00	05400	7,738	0	881	0	54.00
55.00	05500	2,691	0	576	0	55.00
57.00	05700	4,374	0	1,651	0	57.00
58.00	05800	2,355	0	339	0	58.00
59.00	05900	5,046	0	2,449	0	59.00
60.00	06000	0	0	1,866	0	60.00
64.00	06400	0	0	0	0	64.00
65.00	06500	8,074	0	465	0	65.00
66.00	06600	4,374	0	251	0	66.00
67.00	06700	2,691	0	69	0	67.00
68.00	06800	673	0	15	0	68.00
69.00	06900	6,392	0	606	0	69.00
70.00	07000	2,019	0	131	0	70.00
71.00	07100	3,364	0	755	0	71.00
72.00	07200	0	0	791	0	72.00
73.00	07300	10,766	0	1,503	0	73.00
74.00	07400	0	0	52	0	74.00
76.00	03950	2,355	0	244	0	76.00
76.06	03330	0	0	408	0	76.06
76.97	07697	2,019	0	46	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	0	0	0	0	90.00
90.01	04950	0	0	0	0	90.01
90.02	04951	0	0	28	0	90.02
90.03	04952	0	0	0	0	90.03
90.04	04953	0	0	10	0	90.04
91.00	09100	24,223	8,655	3,432	0	91.00
92.00	09200	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		237,518	45,316	24,132	61,299	0
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0	0	190.00
191.00	19100	0	0	0	0	191.00
192.00	19200	0	0	0	0	192.00
193.00	19300	0	0	0	0	193.00
194.00	07950	0	0	0	0	194.00
194.06	07956	0	0	0	0	194.06
194.08	07958	0	0	0	0	194.08
200.00						14,540
201.00		0	0	0	0	0
202.00		237,518	45,316	24,132	61,299	14,540

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/30/2022 2:34 pm
Cost Center Description	INTERNS & RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	SERVICES-OTHER PRGM. COSTS				
	22.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	34,902		22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	3,460,185	0	3,460,185
31.00	03100	INTENSIVE CARE UNIT	1,011,758	0	1,011,758
43.00	04300	NURSERY	94,038	0	94,038
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	3,312,745	0	3,312,745
51.00	05100	RECOVERY ROOM	346,300	0	346,300
52.00	05200	DELIVERY ROOM & LABOR ROOM	408,939	0	408,939
54.00	05400	RADIOLOGY-DIAGNOSTIC	643,199	0	643,199
55.00	05500	RADIOLOGY-THERAPEUTIC	273,494	0	273,494
57.00	05700	CT SCAN	126,740	0	126,740
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	72,460	0	72,460
59.00	05900	CARDIAC CATHETERIZATION	778,105	0	778,105
60.00	06000	LABORATORY	258,286	0	258,286
64.00	06400	INTRAVENOUS THERAPY	0	0	0
65.00	06500	RESPIRATORY THERAPY	148,973	0	148,973
66.00	06600	PHYSICAL THERAPY	646,499	0	646,499
67.00	06700	OCCUPATIONAL THERAPY	45,756	0	45,756
68.00	06800	SPEECH PATHOLOGY	9,976	0	9,976
69.00	06900	ELECTROCARDIOLOGY	294,209	0	294,209
70.00	07000	ELECTROENCEPHALOGRAPHY	186,328	0	186,328
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,746,779	0	1,746,779
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	155,295	0	155,295
73.00	07300	DRUGS CHARGED TO PATIENTS	863,053	0	863,053
74.00	07400	RENAL DIALYSIS	37,639	0	37,639
76.00	03950	ENDOSCOPY	228,723	0	228,723
76.06	03330	IMAGING CENTER	418,343	0	418,343
76.97	07697	CARDIAC REHABILITATION	25,093	0	25,093
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	0
90.01	04950	DIABETIC CARE CENTER	0	0	0
90.02	04951	ANTI-COAGULATION CLINIC	7,548	0	7,548
90.03	04952	PALLIATIVE CARE	0	0	0
90.04	04953	SPINE CENTER	75,423	0	75,423
91.00	09100	EMERGENCY	1,144,404	0	1,144,404
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	16,820,290	16,820,290
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0
191.00	19100	RESEARCH	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,773	0	1,773
193.00	19300	NONPAID WORKERS	0	0	0
194.00	07950	HOME OFFICE	0	0	0
194.06	07956	LEASED OFFICE SPACE	0	0	0
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	36,858	0	36,858
200.00		Cross Foot Adjustments	34,902	49,442	49,442
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118 through 201)	34,902	16,908,363	16,908,363

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1  
Date/Time Prepared:  
5/30/2022 2:34 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	CAP REL COSTS-BLDG & FIXT	371,518					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		9,432,778				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	72,293,887			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	19,216	2,382,709	4,466,277	-45,165,436	172,607,117	5.00
7.00 00700	OPERATION OF PLANT	68,457	52,041	840,793	0	7,322,526	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,009	0	0	0	692,305	8.00
9.00 00900	HOUSEKEEPING	2,143	13,185	1,561,606	0	2,803,812	9.00
10.00 01000	DIETARY	4,259	7,405	480,996	0	1,145,167	10.00
11.00 01100	CAFETERIA	7,774	17,879	889,585	0	926,781	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	351,129	0	2,659,961	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,517,927	16.00
17.00 01700	SOCIAL SERVICE	996	1,838	1,313,774	0	1,771,053	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	914,558	21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	570	0	0	0	1,249,265	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	89,445	201,929	22,319,089	0	36,418,802	30.00
31.00 03100	INTENSIVE CARE UNIT	27,085	177,012	3,494,358	0	5,630,718	31.00
43.00 04300	NURSERY	2,414	9,733	563,425	0	870,041	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	37,911	2,148,494	3,878,122	0	10,836,548	50.00
51.00 05100	RECOVERY ROOM	7,845	45,650	3,210,044	0	4,799,234	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	10,726	43,251	3,131,554	0	4,547,948	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	12,863	249,271	1,815,248	0	3,055,477	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	249,914	730,920	0	1,454,006	55.00
57.00 05700	CT SCAN	1,703	40,633	991,402	0	2,090,189	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,554	15,554	515,238	0	843,614	58.00
59.00 05900	CARDIAC CATHETERIZATION	10,252	446,697	1,454,016	0	3,731,395	59.00
60.00 06000	LABORATORY	4,749	11	0	0	8,245,769	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	2,356	25,804	2,331,464	0	3,321,301	65.00
66.00 06600	PHYSICAL THERAPY	796	564,602	2,538,741	0	4,011,651	66.00
67.00 06700	OCCUPATIONAL THERAPY	211	22,622	676,451	0	950,219	67.00
68.00 06800	SPEECH PATHOLOGY	46	4,880	145,930	0	204,999	68.00
69.00 06900	ELECTROCARDIOLOGY	5,576	110,905	1,139,714	0	1,927,196	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	2,308	107,230	495,218	0	1,098,854	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,741	1,211,621	520,807	0	16,588,100	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,718,482	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	5,843	488,257	3,216,707	0	13,513,209	73.00
74.00 07400	RENAL DIALYSIS	1,076	0	0	0	578,332	74.00
76.00 03950	ENDOSCOPY	0	207,380	708,952	0	1,352,508	76.00
76.06 03330	IMAGING CENTER	0	391,380	979,363	0	1,997,815	76.06
76.97 07697	CARDIAC REHABILITATION	0	15,491	346,356	0	487,069	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	0	0	0	0	0	90.00
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02 04951	ANTI-COAGULATION CLINIC	0	720	558,138	0	428,328	90.02
90.03 04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04 04953	SPINE CENTER	0	70,017	226,699	0	397,944	90.04
91.00 09100	EMERGENCY	31,052	108,584	5,727,310	0	10,978,676	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	370,976	9,432,699	71,619,426	-45,165,436	171,081,779	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	111,520	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	0	194.00
194.06 07956	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	542	79	674,461	0	1,413,818	194.08
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)	7,601,050	9,307,313	3,573,067		45,165,436	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	20.459439	0.986699	0.049424		0.261666	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		2,744,163	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1  
Date/Time Prepared:  
5/30/2022 2:34 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
205.00	Unit cost multiplier (Wkst. B, Part II)					205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)		0.000000		0.015898	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1  
Date/Time Prepared:  
5/30/2022 2:34 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	283,845				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,009	147,086			8.00
9.00	00900	HOUSEKEEPING	2,143	0	280,693		9.00
10.00	01000	DIETARY	4,259	0	4,259	36,894	10.00
11.00	01100	CAFETERIA	7,774	0	7,774	0	706
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	9
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
17.00	01700	SOCIAL SERVICE	996	0	996	0	15
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	570	0	570	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	89,445	68,719	89,445	33,784	267
31.00	03100	INTENSIVE CARE UNIT	27,085	7,197	27,085	3,110	32
43.00	04300	NURSERY	2,414	1,268	2,414	0	6
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	37,911	0	37,911	0	51
51.00	05100	RECOVERY ROOM	7,845	22,414	7,845	0	34
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,726	5,636	10,726	0	27
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,863	2,430	12,863	0	23
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,057	0	0	8
57.00	05700	CT SCAN	1,703	9,692	1,703	0	13
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,554	0	1,554	0	7
59.00	05900	CARDIAC CATHETERIZATION	10,252	0	10,252	0	15
60.00	06000	LABORATORY	4,749	0	4,749	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	2,356	0	2,356	0	24
66.00	06600	PHYSICAL THERAPY	796	0	796	0	13
67.00	06700	OCCUPATIONAL THERAPY	211	0	211	0	8
68.00	06800	SPEECH PATHOLOGY	46	0	46	0	2
69.00	06900	ELECTROCARDIOLOGY	5,576	0	5,576	0	19
70.00	07000	ELECTROENCEPHALOGRAPHY	2,308	0	2,308	0	6
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,741	0	10,741	0	10
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	5,843	0	5,843	0	32
74.00	07400	RENAL DIALYSIS	1,076	0	1,076	0	0
76.00	03950	ENDOSCOPY	0	0	0	0	7
76.06	03330	IMAGING CENTER	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	6
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	0
90.03	04952	PALLIATIVE CARE	0	0	0	0	0
90.04	04953	SPINE CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	31,052	27,673	31,052	0	72
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	283,303	147,086	280,151	36,894	706
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	HOME OFFICE	0	0	0	0	0
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	0
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	542	0	542	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	9,238,582	906,299	3,607,224	1,638,173	1,522,221
203.00		Unit cost multiplier (Wkst. B, Part I)	32.547982	6.161695	12.851136	44.402152	2,156.120397
204.00		Cost to be allocated (per Wkst. B, Part II)	1,568,355	37,225	113,271	137,902	237,518
205.00		Unit cost multiplier (Wkst. B, Part II)	5.525392	0.253083	0.403541	3.737789	336.427762
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1

Date/Time Prepared:  
5/30/2022 2:34 pm

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



COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1  
Date/Time Prepared:  
5/30/2022 2:34 pm

Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS			
				SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
				13.00	16.00		17.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00	
5.00 00500 ADMINISTRATIVE & GENERAL						5.00	
7.00 00700 OPERATION OF PLANT						7.00	
8.00 00800 LAUNDRY & LINEN SERVICE						8.00	
9.00 00900 HOUSEKEEPING						9.00	
10.00 01000 DIETARY						10.00	
11.00 01100 CAFETERIA						11.00	
13.00 01300 NURSING ADMINISTRATION	377					13.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	1,053,504,688				16.00	
17.00 01700 SOCIAL SERVICE	0	0	42,473			17.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	87,215		21.00	
22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	87,215	22.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	267	127,995,917	36,766	62,860	62,860	30.00	
31.00 03100 INTENSIVE CARE UNIT	32	13,402,256	3,110	5,068	5,068	31.00	
43.00 04300 NURSERY	6	4,005,628	2,597	0	0	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0	129,628,996	0	4,164	4,164	50.00	
51.00 05100 RECOVERY ROOM	0	36,084,472	0	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	17,799,989	0	0	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	38,295,639	0	0	0	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	0	25,056,734	0	0	0	55.00	
57.00 05700 CT SCAN	0	71,772,096	0	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	14,734,080	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	106,490,228	0	0	0	59.00	
60.00 06000 LABORATORY	0	81,139,501	0	0	0	60.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	0	20,202,674	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0	10,899,364	0	2,493	2,493	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	2,987,298	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	644,167	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	26,339,549	0	0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	5,685,767	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	32,845,066	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	34,408,037	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	65,329,833	0	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	2,276,264	0	0	0	74.00	
76.00 03950 ENDOSCOPY	0	10,609,532	0	0	0	76.00	
76.06 03330 IMAGING CENTER	0	17,754,504	0	0	0	76.06	
76.97 07697 CARDIAC REHABILITATION	0	1,995,908	0	0	0	76.97	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
90.01 04950 DIABETIC CARE CENTER	0	0	0	0	0	90.01	
90.02 04951 ANTI-COAGULATION CLINIC	0	1,198,742	0	0	0	90.02	
90.03 04952 PALLIATIVE CARE	0	0	0	0	0	90.03	
90.04 04953 SPINE CENTER	0	429,317	0	0	0	90.04	
91.00 09100 EMERGENCY	72	153,493,130	0	10,027	10,027	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	377	1,053,504,688	42,473	84,612	84,612	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	959	959	192.00	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
194.00 07950 HOME OFFICE	0	0	0	0	0	194.00	
194.06 07956 LEASED OFFICE SPACE	0	0	0	0	0	194.06	
194.08 07958 MISC NONREIMBURSABLE COST CENTERS	0	0	0	1,644	1,644	194.08	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers					201.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	3,375,387	1,915,117	2,312,037	1,153,867	1,602,032	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8,953.281167	0.001818	54.435453	13.230144	18.368767	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	45,316	24,132	61,299	14,540	34,902	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1

Date/Time Prepared:  
5/30/2022 2:34 pm

Cost Center Description	NURSING ADMINISTRATION  (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE  (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS			
				SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
				13.00	16.00		17.00
205.00	Unit cost multiplier (Wkst. B, Part II)	120.201592	0.000023	1.443246	0.166714	0.400183	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: 15-0128

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2022 2:34 pm

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		57,132,900	0	57,132,900	30.00	
31.00	03100 INTENSIVE CARE UNIT		9,065,317	0	9,065,317	31.00	
43.00	04300 NURSERY		1,430,416	0	1,430,416	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		15,738,858	0	15,738,858	50.00	
51.00	05100 RECOVERY ROOM		6,688,204	0	6,688,204	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		6,350,244	0	6,350,244	52.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,573,145	0	4,573,145	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC		1,909,947	0	1,909,947	55.00	
57.00	05700 CT SCAN		2,932,665	0	2,932,665	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,176,790	0	1,176,790	58.00	
59.00	05900 CARDIAC CATHETERIZATION		5,399,147	0	5,399,147	59.00	
60.00	06000 LABORATORY		10,766,518	0	10,766,518	60.00	
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0	4,385,808	0	4,385,808	65.00	
66.00	06600 PHYSICAL THERAPY	0	5,145,347	0	5,145,347	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	1,231,119	0	1,231,119	67.00	
68.00	06800 SPEECH PATHOLOGY	0	266,211	0	266,211	68.00	
69.00	06900 ELECTROCARDIOLOGY		2,773,475	0	2,773,475	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY		1,514,442	0	1,514,442	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		21,497,547	0	21,497,547	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		12,324,032	0	12,324,032	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		17,502,189	0	17,502,189	73.00	
74.00	07400 RENAL DIALYSIS		782,650	0	782,650	74.00	
76.00	03950 ENDOSCOPY		1,740,794	0	1,740,794	76.00	
76.06	03330 IMAGING CENTER		2,552,853	0	2,552,853	76.06	
76.97	07697 CARDIAC REHABILITATION		631,084	0	631,084	76.97	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC		0	0	0	90.00	
90.01	04950 DIABETIC CARE CENTER		0	0	0	90.01	
90.02	04951 ANTI-COAGULATION CLINIC		542,586	0	542,586	90.02	
90.03	04952 PALLIATIVE CARE		0	0	0	90.03	
90.04	04953 SPINE CENTER		502,852	0	502,852	90.04	
91.00	09100 EMERGENCY		16,510,441	0	16,510,441	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		7,365,155	0	7,365,155	92.00	
200.00	Subtotal (see instructions)		220,432,736	0	220,432,736	200.00	
201.00	Less Observation Beds		7,365,155	0	7,365,155	201.00	
202.00	Total (see instructions)		213,067,581	0	213,067,581	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/30/2022 2:34 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
	9.00	10.00				
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	118,861,764		118,861,764	30.00
31.00	03100	INTENSIVE CARE UNIT	13,402,256		13,402,256	31.00
43.00	04300	NURSERY	4,005,628		4,005,628	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	59,033,064	70,595,932	129,628,996	50.00
51.00	05100	RECOVERY ROOM	11,615,827	24,468,645	36,084,472	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,799,989	0	17,799,989	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,404,056	30,891,583	38,295,639	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	8,625,413	16,431,321	25,056,734	55.00
57.00	05700	CT SCAN	19,248,384	52,523,712	71,772,096	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,379,279	11,354,801	14,734,080	58.00
59.00	05900	CARDIAC CATHETERIZATION	38,858,987	67,631,241	106,490,228	59.00
60.00	06000	LABORATORY	48,093,647	33,045,854	81,139,501	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	18,367,743	1,834,931	20,202,674	65.00
66.00	06600	PHYSICAL THERAPY	2,781,845	8,117,519	10,899,364	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,048,827	938,471	2,987,298	67.00
68.00	06800	SPEECH PATHOLOGY	478,776	165,391	644,167	68.00
69.00	06900	ELECTROCARDIOLOGY	6,508,148	19,831,401	26,339,549	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	454,164	5,231,603	5,685,767	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,729,594	17,115,472	32,845,066	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,289,174	16,118,863	34,408,037	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,527,232	16,802,601	65,329,833	73.00
74.00	07400	RENAL DIALYSIS	2,276,264	0	2,276,264	74.00
76.00	03950	ENDOSCOPY	2,267,409	8,342,123	10,609,532	76.00
76.06	03330	IMAGING CENTER	157,833	17,596,671	17,754,504	76.06
76.97	07697	CARDIAC REHABILITATION	1,896	1,994,012	1,995,908	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	6,412	1,192,330	1,198,742	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	90.03
90.04	04953	SPINE CENTER	0	429,317	429,317	90.04
91.00	09100	EMERGENCY	34,752,161	118,740,969	153,493,130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,678,777	6,455,376	9,134,153	92.00
200.00		Subtotal (see instructions)	505,654,549	547,850,139	1,053,504,688	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	505,654,549	547,850,139	1,053,504,688	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/30/2022 2:34 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.121415		50.00
51.00	05100 RECOVERY ROOM	0.185349		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.356756		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.119417		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.076225		55.00
57.00	05700 CT SCAN	0.040861		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.079869		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.050701		59.00
60.00	06000 LABORATORY	0.132691		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.217090		65.00
66.00	06600 PHYSICAL THERAPY	0.472078		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.412118		67.00
68.00	06800 SPEECH PATHOLOGY	0.413264		68.00
69.00	06900 ELECTROCARDIOLOGY	0.105297		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.266357		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.654514		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.358173		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.267905		73.00
74.00	07400 RENAL DIALYSIS	0.343831		74.00
76.00	03950 ENDOSCOPY	0.164078		76.00
76.06	03330 IMAGING CENTER	0.143786		76.06
76.97	07697 CARDIAC REHABILITATION	0.316189		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
90.01	04950 DIABETIC CARE CENTER	0.000000		90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.452630		90.02
90.03	04952 PALLIATIVE CARE	0.000000		90.03
90.04	04953 SPINE CENTER	1.171284		90.04
91.00	09100 EMERGENCY	0.107565		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.806331		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: 15-0128

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2022 2:34 pm

		Title XIX		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	59,119,207		59,119,207	0	59,119,207	30.00
31.00	03100 INTENSIVE CARE UNIT	9,225,460		9,225,460	0	9,225,460	31.00
43.00	04300 NURSERY	1,430,416		1,430,416	0	1,430,416	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	15,870,436		15,870,436	0	15,870,436	50.00
51.00	05100 RECOVERY ROOM	6,688,204		6,688,204	0	6,688,204	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6,350,244		6,350,244	0	6,350,244	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,573,145		4,573,145	0	4,573,145	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	1,909,947		1,909,947	0	1,909,947	55.00
57.00	05700 CT SCAN	2,932,665		2,932,665	0	2,932,665	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,176,790		1,176,790	0	1,176,790	58.00
59.00	05900 CARDIAC CATHETERIZATION	5,399,147		5,399,147	0	5,399,147	59.00
60.00	06000 LABORATORY	10,766,518		10,766,518	0	10,766,518	60.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	4,385,808	0	4,385,808	0	4,385,808	65.00
66.00	06600 PHYSICAL THERAPY	5,224,123	0	5,224,123	0	5,224,123	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,231,119	0	1,231,119	0	1,231,119	67.00
68.00	06800 SPEECH PATHOLOGY	266,211	0	266,211	0	266,211	68.00
69.00	06900 ELECTROCARDIOLOGY	2,773,475		2,773,475	0	2,773,475	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,514,442		1,514,442	0	1,514,442	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21,497,547		21,497,547	0	21,497,547	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	12,324,032		12,324,032	0	12,324,032	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	17,502,189		17,502,189	0	17,502,189	73.00
74.00	07400 RENAL DIALYSIS	782,650		782,650	0	782,650	74.00
76.00	03950 ENDOSCOPY	1,740,794		1,740,794	0	1,740,794	76.00
76.06	03330 IMAGING CENTER	2,552,853		2,552,853	0	2,552,853	76.06
76.97	07697 CARDIAC REHABILITATION	631,084		631,084	0	631,084	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0		0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0		0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	542,586		542,586	0	542,586	90.02
90.03	04952 PALLIATIVE CARE	0		0	0	0	90.03
90.04	04953 SPINE CENTER	502,852		502,852	0	502,852	90.04
91.00	09100 EMERGENCY	16,827,284		16,827,284	0	16,827,284	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7,365,155		7,365,155	0	7,365,155	92.00
200.00	Subtotal (see instructions)	223,106,383	0	223,106,383	0	223,106,383	200.00
201.00	Less Observation Beds	7,365,155		7,365,155	0	7,365,155	201.00
202.00	Total (see instructions)	215,741,228	0	215,741,228	0	215,741,228	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0128		Period: From 01/01/2021 To 12/31/2021		Worksheet C Part I Date/Time Prepared: 5/30/2022 2:34 pm	
			Title XIX		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	118,861,764		118,861,764			30.00
31.00	03100	INTENSIVE CARE UNIT	13,402,256		13,402,256			31.00
43.00	04300	NURSERY	4,005,628		4,005,628			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	59,033,064	70,595,932	129,628,996	0.122430	0.000000	50.00
51.00	05100	RECOVERY ROOM	11,615,827	24,468,645	36,084,472	0.185349	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,799,989	0	17,799,989	0.356756	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,404,056	30,891,583	38,295,639	0.119417	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	8,625,413	16,431,321	25,056,734	0.076225	0.000000	55.00
57.00	05700	CT SCAN	19,248,384	52,523,712	71,772,096	0.040861	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,379,279	11,354,801	14,734,080	0.079869	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	38,858,987	67,631,241	106,490,228	0.050701	0.000000	59.00
60.00	06000	LABORATORY	48,093,647	33,045,854	81,139,501	0.132691	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	18,367,743	1,834,931	20,202,674	0.217090	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,781,845	8,117,519	10,899,364	0.479305	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,048,827	938,471	2,987,298	0.412118	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	478,776	165,391	644,167	0.413264	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	6,508,148	19,831,401	26,339,549	0.105297	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	454,164	5,231,603	5,685,767	0.266357	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,729,594	17,115,472	32,845,066	0.654514	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,289,174	16,118,863	34,408,037	0.358173	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,527,232	16,802,601	65,329,833	0.267905	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,276,264	0	2,276,264	0.343831	0.000000	74.00
76.00	03950	ENDOSCOPY	2,267,409	8,342,123	10,609,532	0.164078	0.000000	76.00
76.06	03330	IMAGING CENTER	157,833	17,596,671	17,754,504	0.143786	0.000000	76.06
76.97	07697	CARDIAC REHABILITATION	1,896	1,994,012	1,995,908	0.316189	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0.000000	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	6,412	1,192,330	1,198,742	0.452630	0.000000	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0.000000	0.000000	90.03
90.04	04953	SPINE CENTER	0	429,317	429,317	1.171284	0.000000	90.04
91.00	09100	EMERGENCY	34,752,161	118,740,969	153,493,130	0.109629	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,678,777	6,455,376	9,134,153	0.806331	0.000000	92.00
200.00		Subtotal (see instructions)	505,654,549	547,850,139	1,053,504,688			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	505,654,549	547,850,139	1,053,504,688			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/30/2022 2:34 pm
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.122430		50.00
51.00	05100 RECOVERY ROOM	0.185349		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.356756		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.119417		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.076225		55.00
57.00	05700 CT SCAN	0.040861		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.079869		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.050701		59.00
60.00	06000 LABORATORY	0.132691		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.217090		65.00
66.00	06600 PHYSICAL THERAPY	0.479305		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.412118		67.00
68.00	06800 SPEECH PATHOLOGY	0.413264		68.00
69.00	06900 ELECTROCARDIOLOGY	0.105297		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.266357		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.654514		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.358173		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.267905		73.00
74.00	07400 RENAL DIALYSIS	0.343831		74.00
76.00	03950 ENDOSCOPY	0.164078		76.00
76.06	03330 IMAGING CENTER	0.143786		76.06
76.97	07697 CARDIAC REHABILITATION	0.316189		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
90.01	04950 DIABETIC CARE CENTER	0.000000		90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.452630		90.02
90.03	04952 PALLIATIVE CARE	0.000000		90.03
90.04	04953 SPINE CENTER	1.171284		90.04
91.00	09100 EMERGENCY	0.109629		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.806331		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00



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

Provider CCN: 15-0128

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

Worksheet C Part II Date/Time Prepared: 5/30/2022 2:34 pm

Cost Center Description			Title XIX			Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	15,870,436	3,312,745	12,557,691	0	0	50.00
51.00	05100	RECOVERY ROOM	6,688,204	346,300	6,341,904	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,350,244	408,939	5,941,305	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,573,145	643,199	3,929,946	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,909,947	273,494	1,636,453	0	0	55.00
57.00	05700	CT SCAN	2,932,665	126,740	2,805,925	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,176,790	72,460	1,104,330	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,399,147	778,105	4,621,042	0	0	59.00
60.00	06000	LABORATORY	10,766,518	258,286	10,508,232	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,385,808	148,973	4,236,835	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,224,123	646,499	4,577,624	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,231,119	45,756	1,185,363	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	266,211	9,976	256,235	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,773,475	294,209	2,479,266	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,514,442	186,328	1,328,114	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,497,547	1,746,779	19,750,768	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,324,032	155,295	12,168,737	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,502,189	863,053	16,639,136	0	0	73.00
74.00	07400	RENAL DIALYSIS	782,650	37,639	745,011	0	0	74.00
76.00	03950	ENDOSCOPY	1,740,794	228,723	1,512,071	0	0	76.00
76.06	03330	IMAGING CENTER	2,552,853	418,343	2,134,510	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	631,084	25,093	605,991	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	542,586	7,548	535,038	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	502,852	75,423	427,429	0	0	90.04
91.00	09100	EMERGENCY	16,827,284	1,144,404	15,682,880	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,365,155	446,063	6,919,092	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	153,331,300	12,700,372	140,630,928	0	0	200.00
201.00		Less Observation Beds	7,365,155	446,063	6,919,092	0	0	201.00
202.00		Total (line 200 minus line 201)	145,966,145	12,254,309	133,711,836	0	0	202.00

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

Provider CCN: 15-0128

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

Worksheet C Part II Date/Time Prepared: 5/30/2022 2:34 pm

Cost Center Description		Title XIX			Hospital	PPS
		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
		6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	15,870,436	129,628,996	0.122430	50.00
51.00	05100	RECOVERY ROOM	6,688,204	36,084,472	0.185349	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,350,244	17,799,989	0.356756	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,573,145	38,295,639	0.119417	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,909,947	25,056,734	0.076225	55.00
57.00	05700	CT SCAN	2,932,665	71,772,096	0.040861	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,176,790	14,734,080	0.079869	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,399,147	106,490,228	0.050701	59.00
60.00	06000	LABORATORY	10,766,518	81,139,501	0.132691	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,385,808	20,202,674	0.217090	65.00
66.00	06600	PHYSICAL THERAPY	5,224,123	10,899,364	0.479305	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,231,119	2,987,298	0.412118	67.00
68.00	06800	SPEECH PATHOLOGY	266,211	644,167	0.413264	68.00
69.00	06900	ELECTROCARDIOLOGY	2,773,475	26,339,549	0.105297	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,514,442	5,685,767	0.266357	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,497,547	32,845,066	0.654514	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,324,032	34,408,037	0.358173	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,502,189	65,329,833	0.267905	73.00
74.00	07400	RENAL DIALYSIS	782,650	2,276,264	0.343831	74.00
76.00	03950	ENDOSCOPY	1,740,794	10,609,532	0.164078	76.00
76.06	03330	IMAGING CENTER	2,552,853	17,754,504	0.143786	76.06
76.97	07697	CARDIAC REHABILITATION	631,084	1,995,908	0.316189	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	0	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	542,586	1,198,742	0.452630	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	90.03
90.04	04953	SPINE CENTER	502,852	429,317	1.171284	90.04
91.00	09100	EMERGENCY	16,827,284	153,493,130	0.109629	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,365,155	9,134,153	0.806331	92.00
200.00		Subtotal (sum of lines 50 thru 199)	153,331,300	917,235,040		200.00
201.00		Less Observation Beds	7,365,155	0		201.00
202.00		Total (line 200 minus line 201)	145,966,145	917,235,040		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Prepared: 5/30/2022 2:34 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	3,460,185	0	3,460,185	42,207	81.98	30.00
31.00	INTENSIVE CARE UNIT	1,011,758		1,011,758	3,110	325.32	31.00
43.00	NURSERY	94,038		94,038	2,597	36.21	43.00
200.00	Total (Lines 30 through 199)	4,565,981		4,565,981	47,914		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	10,289	843,492				
31.00	INTENSIVE CARE UNIT	935	304,174				
43.00	NURSERY	0	0				
200.00	Total (Lines 30 through 199)	11,224	1,147,666				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Prepared: 5/30/2022 2:34 pm
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	3,312,745	129,628,996	0.025556	17,139,862	438,026	50.00
51.00	05100	RECOVERY ROOM	346,300	36,084,472	0.009597	2,557,616	24,545	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	408,939	17,799,989	0.022974	16,943	389	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	643,199	38,295,639	0.016796	2,490,075	41,823	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	273,494	25,056,734	0.010915	2,740,590	29,914	55.00
57.00	05700	CT SCAN	126,740	71,772,096	0.001766	6,174,770	10,905	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	72,460	14,734,080	0.004918	1,130,306	5,559	58.00
59.00	05900	CARDIAC CATHETERIZATION	778,105	106,490,228	0.007307	11,781,363	86,086	59.00
60.00	06000	LABORATORY	258,286	81,139,501	0.003183	14,724,114	46,867	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	148,973	20,202,674	0.007374	4,758,520	35,089	65.00
66.00	06600	PHYSICAL THERAPY	646,499	10,899,364	0.059315	962,897	57,114	66.00
67.00	06700	OCCUPATIONAL THERAPY	45,756	2,987,298	0.015317	779,279	11,936	67.00
68.00	06800	SPEECH PATHOLOGY	9,976	644,167	0.015487	168,723	2,613	68.00
69.00	06900	ELECTROCARDIOLOGY	294,209	26,339,549	0.011170	2,432,127	27,167	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	186,328	5,685,767	0.032771	156,451	5,127	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,746,779	32,845,066	0.053182	3,672,879	195,331	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	155,295	34,408,037	0.004513	4,990,137	22,520	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	863,053	65,329,833	0.013211	13,192,306	174,284	73.00
74.00	07400	RENAL DIALYSIS	37,639	2,276,264	0.016535	0	0	74.00
76.00	03950	ENDOSCOPY	228,723	10,609,532	0.021558	60,011	1,294	76.00
76.06	03330	IMAGING CENTER	418,343	17,754,504	0.023563	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	25,093	1,995,908	0.012572	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	7,548	1,198,742	0.006297	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	75,423	429,317	0.175681	0	0	90.04
91.00	09100	EMERGENCY	1,144,404	153,493,130	0.007456	11,031,353	82,250	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	446,063	9,134,153	0.048835	2,059,801	100,590	92.00
200.00		Total (lines 50 through 199)	12,700,372	917,235,040		103,020,123	1,399,429	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0128		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 5/30/2022 2:34 pm		
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS			1A	1.00	2A	2.00	3.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
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		
INPATIENT ROUTINE SERVICE COST CENTERS			4.00	5.00	6.00	7.00	8.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	42,207	0.00	10,289	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	3,110	0.00	935	31.00	
43.00	04300	NURSERY		0	2,597	0.00	0	43.00	
200.00		Total (lines 30 through 199)		0	47,914		11,224	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
INPATIENT ROUTINE SERVICE COST CENTERS			9.00						
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
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: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/30/2022 2:34 pm
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Cost Center Description	Title XVIII						Hospital	
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	PPS		
	1.00	2A	2.00	3A	3.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	0	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/30/2022 2:34 pm
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Cost Center Description	Title XVIII				Hospital	PPS		
	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			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	129,628,996	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	36,084,472	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	17,799,989	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,295,639	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	25,056,734	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	71,772,096	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	14,734,080	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	106,490,228	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	81,139,501	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	20,202,674	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,899,364	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,987,298	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	644,167	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	26,339,549	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,685,767	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	32,845,066	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	34,408,037	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	65,329,833	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,276,264	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	10,609,532	0.000000	76.00
76.06	03330	IMAGING CENTER	0	0	0	17,754,504	0.000000	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,995,908	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	1,198,742	0.000000	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0.000000	90.03
90.04	04953	SPINE CENTER	0	0	0	429,317	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	153,493,130	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	9,134,153	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	917,235,040		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/30/2022 2:34 pm
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Cost Center Description		Title XVIII				Hospital		
		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)	PPS	
		9.00	10.00	11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.000000	17,139,862	0	11,209,856	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	2,557,616	0	4,806,124	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	16,943	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,490,075	0	5,648,466	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	2,740,590	0	6,952,451	0	55.00
57.00	05700	CT SCAN	0.000000	6,174,770	0	8,547,485	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	1,130,306	0	2,386,727	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	11,781,363	0	21,192,729	0	59.00
60.00	06000	LABORATORY	0.000000	14,724,114	0	4,875,207	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,758,520	0	288,070	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	962,897	0	43,132	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	779,279	0	7,675	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	168,723	0	4,543	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,432,127	0	5,150,398	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	156,451	0	816,065	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	3,672,879	0	3,931,252	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,990,137	0	5,645,465	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	13,192,306	0	4,295,459	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.000000	60,011	0	1,628,647	0	76.00
76.06	03330	IMAGING CENTER	0.000000	0	0	2,995,888	0	76.06
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	625,118	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.000000	0	0	453,110	0	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	11,031,353	0	12,191,024	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,059,801	0	2,567,821	0	92.00
200.00		Total (lines 50 through 199)		103,020,123	0	106,262,712	0	200.00



APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/30/2022 2:34 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.121415	11,209,856	0	0	1,361,045	50.00
51.00	05100	RECOVERY ROOM	0.185349	4,806,124	0	0	890,810	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.356756	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119417	5,648,466	0	0	674,523	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.076225	6,952,451	0	0	529,951	55.00
57.00	05700	CT SCAN	0.040861	8,547,485	0	0	349,259	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.079869	2,386,727	0	0	190,625	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.050701	21,192,729	0	0	1,074,493	59.00
60.00	06000	LABORATORY	0.132691	4,875,207	0	0	646,896	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.217090	288,070	0	0	62,537	65.00
66.00	06600	PHYSICAL THERAPY	0.472078	43,132	0	0	20,362	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.412118	7,675	0	0	3,163	67.00
68.00	06800	SPEECH PATHOLOGY	0.413264	4,543	0	0	1,877	68.00
69.00	06900	ELECTROCARDIOLOGY	0.105297	5,150,398	0	0	542,321	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.266357	816,065	0	0	217,365	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.654514	3,931,252	0	0	2,573,059	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.358173	5,645,465	0	0	2,022,053	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.267905	4,295,459	0	31,239	1,150,775	73.00
74.00	07400	RENAL DIALYSIS	0.343831	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.164078	1,628,647	0	0	267,225	76.00
76.06	03330	IMAGING CENTER	0.143786	2,995,888	0	0	430,767	76.06
76.97	07697	CARDIAC REHABILITATION	0.316189	625,118	0	0	197,655	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.452630	453,110	0	0	205,091	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953	SPINE CENTER	1.171284	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.107565	12,191,024	0	0	1,311,327	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.806331	2,567,821	0	0	2,070,514	92.00
200.00		Subtotal (see instructions)		106,262,712	0	31,239	16,793,693	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		106,262,712	0	31,239	16,793,693	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/30/2022 2:34 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8,369	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03950 ENDOSCOPY	0	0	76.00
76.06	03330 IMAGING CENTER	0	0	76.06
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0	0	90.02
90.03	04952 PALLIATIVE CARE	0	0	90.03
90.04	04953 SPINE CENTER	0	0	90.04
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	8,369	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	8,369	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0128		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part I Date/Time Prepared: 5/30/2022 2:34 pm	
Cost Center Description		Title XIX		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,460,185	0	3,460,185	42,207	81.98	30.00
31.00	INTENSIVE CARE UNIT	1,011,758		1,011,758	3,110	325.32	31.00
43.00	NURSERY	94,038		94,038	2,597	36.21	43.00
200.00	Total (Lines 30 through 199)	4,565,981		4,565,981	47,914		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,465	120,101				
31.00	INTENSIVE CARE UNIT	0	0				
43.00	NURSERY	1,455	52,686				
200.00	Total (Lines 30 through 199)	2,920	172,787				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Prepared: 5/30/2022 2:34 pm
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Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	3,312,745	129,628,996	0.025556	841,567	21,507	50.00
51.00	05100	RECOVERY ROOM	346,300	36,084,472	0.009597	201,553	1,934	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	408,939	17,799,989	0.022974	155,551	3,574	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	643,199	38,295,639	0.016796	226,668	3,807	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	273,494	25,056,734	0.010915	212,911	2,324	55.00
57.00	05700	CT SCAN	126,740	71,772,096	0.001766	683,389	1,207	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	72,460	14,734,080	0.004918	87,922	432	58.00
59.00	05900	CARDIAC CATHETERIZATION	778,105	106,490,228	0.007307	866,925	6,335	59.00
60.00	06000	LABORATORY	258,286	81,139,501	0.003183	1,667,286	5,307	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	148,973	20,202,674	0.007374	972,583	7,172	65.00
66.00	06600	PHYSICAL THERAPY	646,499	10,899,364	0.059315	75,877	4,501	66.00
67.00	06700	OCCUPATIONAL THERAPY	45,756	2,987,298	0.015317	43,849	672	67.00
68.00	06800	SPEECH PATHOLOGY	9,976	644,167	0.015487	16,028	248	68.00
69.00	06900	ELECTROCARDIOLOGY	294,209	26,339,549	0.011170	181,468	2,027	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	186,328	5,685,767	0.032771	27,943	916	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,746,779	32,845,066	0.053182	454,737	24,184	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	155,295	34,408,037	0.004513	200,479	905	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	863,053	65,329,833	0.013211	1,863,974	24,625	73.00
74.00	07400	RENAL DIALYSIS	37,639	2,276,264	0.016535	28,014	463	74.00
76.00	03950	ENDOSCOPY	228,723	10,609,532	0.021558	60,083	1,295	76.00
76.06	03330	IMAGING CENTER	418,343	17,754,504	0.023563	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	25,093	1,995,908	0.012572	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	7,548	1,198,742	0.006297	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	75,423	429,317	0.175681	0	0	90.04
91.00	09100	EMERGENCY	1,144,404	153,493,130	0.007456	1,206,921	8,999	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	446,063	9,134,153	0.048835	31,296	1,528	92.00
200.00		Total (lines 50 through 199)	12,700,372	917,235,040		10,107,024	123,962	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Prepared: 5/30/2022 2:34 pm
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Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
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	42,207	0.00	1,465	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	3,110	0.00	0	31.00	
43.00	04300	NURSERY		0	2,597	0.00	1,455	43.00	
200.00		Total (lines 30 through 199)		0	47,914		2,920	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
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: 15-0128

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2022 2:34 pm

Cost Center Description			Title XIX				Hospital	PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health		
			1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	0	0	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/30/2022 2:34 pm
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Title XIX		Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
				Hospital	PPS	
	4.00	5.00	6.00	Total Charges (from Wkst. C, Part I, col. 8)	7.00	8.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	129,628,996	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	36,084,472	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	17,799,989	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	38,295,639	0.000000	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	25,056,734	0.000000	55.00
57.00 05700 CT SCAN	0	0	0	71,772,096	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	14,734,080	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	106,490,228	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	81,139,501	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	20,202,674	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	10,899,364	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	2,987,298	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	644,167	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	26,339,549	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	5,685,767	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	32,845,066	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	34,408,037	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	65,329,833	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	2,276,264	0.000000	74.00
76.00 03950 ENDOSCOPY	0	0	0	10,609,532	0.000000	76.00
76.06 03330 IMAGING CENTER	0	0	0	17,754,504	0.000000	76.06
76.97 07697 CARDIAC REHABILITATION	0	0	0	1,995,908	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0.000000	90.00
90.01 04950 DIABETIC CARE CENTER	0	0	0	0	0.000000	90.01
90.02 04951 ANTI-COAGULATION CLINIC	0	0	0	1,198,742	0.000000	90.02
90.03 04952 PALLIATIVE CARE	0	0	0	0	0.000000	90.03
90.04 04953 SPINE CENTER	0	0	0	429,317	0.000000	90.04
91.00 09100 EMERGENCY	0	0	0	153,493,130	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	9,134,153	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	0	917,235,040		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/30/2022 2:34 pm
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Cost Center Description		Title XIX			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	841,567	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	201,553	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	155,551	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	226,668	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	212,911	0	0	0	55.00
57.00	05700 CT SCAN	0.000000	683,389	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	87,922	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	866,925	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	1,667,286	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	972,583	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	75,877	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	43,849	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	16,028	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	181,468	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	27,943	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	454,737	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	200,479	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	1,863,974	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	28,014	0	0	0	74.00
76.00	03950 ENDOSCOPY	0.000000	60,083	0	0	0	76.00
76.06	03330 IMAGING CENTER	0.000000	0	0	0	0	76.06
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.000000	0	0	0	0	90.02
90.03	04952 PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953 SPINE CENTER	0.000000	0	0	0	0	90.04
91.00	09100 EMERGENCY	0.000000	1,206,921	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	31,296	0	0	0	92.00
200.00	Total (lines 50 through 199)		10,107,024	0	0	0	200.00



APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0128

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

Worksheet D  
Part V  
Date/Time Prepared:  
5/30/2022 2:34 pm

		Title XIX		Hospital		PPS		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.122430	0	770,394	0	0	50.00
51.00	05100	RECOVERY ROOM	0.185349	0	299,740	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.356756	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119417	0	717,469	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.076225	0	275,424	0	0	55.00
57.00	05700	CT SCAN	0.040861	0	1,767,662	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.079869	0	124,184	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.050701	0	311,556	0	0	59.00
60.00	06000	LABORATORY	0.132691	0	1,181,971	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.217090	0	40,707	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.479305	0	57,355	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.412118	0	11,999	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.413264	0	4,548	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.105297	0	166,608	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.266357	0	42,813	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.654514	0	195,823	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.358173	0	44,241	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.267905	0	219,044	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.343831	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.164078	0	69,089	0	0	76.00
76.06	03330	IMAGING CENTER	0.143786	0	145,942	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0.316189	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.452630	0	10,520	0	0	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953	SPINE CENTER	1.171284	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.109629	0	6,017,613	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.806331	0	1,921	0	0	92.00
200.00		Subtotal (see instructions)		0	12,476,623	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	12,476,623	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/30/2022 2:34 pm
		Title XIX	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	94,319	0	50.00
51.00	05100 RECOVERY ROOM	55,557	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	85,678	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	20,994	0	55.00
57.00	05700 CT SCAN	72,228	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	9,918	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	15,796	0	59.00
60.00	06000 LABORATORY	156,837	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	8,837	0	65.00
66.00	06600 PHYSICAL THERAPY	27,491	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	4,945	0	67.00
68.00	06800 SPEECH PATHOLOGY	1,880	0	68.00
69.00	06900 ELECTROCARDIOLOGY	17,543	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	11,404	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	128,169	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	15,846	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	58,683	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03950 ENDOSCOPY	11,336	0	76.00
76.06	03330 IMAGING CENTER	20,984	0	76.06
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	4,762	0	90.02
90.03	04952 PALLIATIVE CARE	0	0	90.03
90.04	04953 SPINE CENTER	0	0	90.04
91.00	09100 EMERGENCY	659,705	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,549	0	92.00
200.00	Subtotal (see instructions)	1,484,461	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)	1,484,461	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/30/2022 2:34 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		42,207	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		42,207	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)		36,766	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		10,289	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		57,132,900	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		57,132,900	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		57,132,900	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,353.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		13,927,602	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)		13,927,602	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/30/2022 2:34 pm	
Cost Center Description			Title XVIII		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9,065,317	3,110	2,914.89	935	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)				18,720,179	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				35,373,203	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				1,147,666	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				1,399,429	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				2,547,095	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				32,826,108	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)				5,441	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,353.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				7,365,155	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/30/2022 2:34 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,460,185	57,132,900	0.060564	7,365,155	446,063	90.00
91.00	Nursing Program cost	0	57,132,900	0.000000	7,365,155	0	91.00
92.00	Allied health cost	0	57,132,900	0.000000	7,365,155	0	92.00
93.00	All other Medical Education	0	57,132,900	0.000000	7,365,155	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/30/2022 2:34 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		42,207	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		42,207	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)		36,766	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,465	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)		2,597	15.00
16.00	Nursery days (title V or XIX only)		1,455	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		59,119,207	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		59,119,207	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		59,119,207	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,400.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,052,026	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,052,026	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/30/2022 2:34 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	PPS
Title XIX		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,430,416	2,597	550.80	1,455	801,414	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	9,225,460	3,110	2,966.39	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,883,913	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,737,353	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)					172,787	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					123,962	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					296,749	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,440,604	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)					5,441	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,400.70	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					7,621,209	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/30/2022 2:34 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,460,185	59,119,207	0.058529	7,621,209	446,062	90.00
91.00	Nursing Program cost	0	59,119,207	0.000000	7,621,209	0	91.00
92.00	Allied health cost	0	59,119,207	0.000000	7,621,209	0	92.00
93.00	All other Medical Education	0	59,119,207	0.000000	7,621,209	0	93.00



INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/30/2022 2:34 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		22,737,403		30.00
31.00	03100 INTENSIVE CARE UNIT		3,703,079		31.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.121415	17,139,862	2,081,036	50.00
51.00	05100 RECOVERY ROOM	0.185349	2,557,616	474,052	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.356756	16,943	6,045	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.119417	2,490,075	297,357	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.076225	2,740,590	208,901	55.00
57.00	05700 CT SCAN	0.040861	6,174,770	252,307	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.079869	1,130,306	90,276	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.050701	11,781,363	597,327	59.00
60.00	06000 LABORATORY	0.132691	14,724,114	1,953,757	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.217090	4,758,520	1,033,027	65.00
66.00	06600 PHYSICAL THERAPY	0.472078	962,897	454,562	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.412118	779,279	321,155	67.00
68.00	06800 SPEECH PATHOLOGY	0.413264	168,723	69,727	68.00
69.00	06900 ELECTROCARDIOLOGY	0.105297	2,432,127	256,096	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.266357	156,451	41,672	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.654514	3,672,879	2,403,951	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.358173	4,990,137	1,787,332	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.267905	13,192,306	3,534,285	73.00
74.00	07400 RENAL DIALYSIS	0.343831	0	0	74.00
76.00	03950 ENDOSCOPY	0.164078	60,011	9,846	76.00
76.06	03330 IMAGING CENTER	0.143786	0	0	76.06
76.97	07697 CARDIAC REHABILITATION	0.316189	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0.000000	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.452630	0	0	90.02
90.03	04952 PALLIATIVE CARE	0.000000	0	0	90.03
90.04	04953 SPINE CENTER	1.171284	0	0	90.04
91.00	09100 EMERGENCY	0.107565	11,031,353	1,186,587	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.806331	2,059,801	1,660,881	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		103,020,123	18,720,179	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		103,020,123		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/30/2022 2:34 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		4,408,339	30.00
31.00	03100	INTENSIVE CARE UNIT		869,611	31.00
43.00	04300	NURSERY		902,666	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.122430	841,567	103,033 50.00
51.00	05100	RECOVERY ROOM	0.185349	201,553	37,358 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.356756	155,551	55,494 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119417	226,668	27,068 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.076225	212,911	16,229 55.00
57.00	05700	CT SCAN	0.040861	683,389	27,924 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.079869	87,922	7,022 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.050701	866,925	43,954 59.00
60.00	06000	LABORATORY	0.132691	1,667,286	221,234 60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.217090	972,583	211,138 65.00
66.00	06600	PHYSICAL THERAPY	0.479305	75,877	36,368 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.412118	43,849	18,071 67.00
68.00	06800	SPEECH PATHOLOGY	0.413264	16,028	6,624 68.00
69.00	06900	ELECTROCARDIOLOGY	0.105297	181,468	19,108 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.266357	27,943	7,443 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.654514	454,737	297,632 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.358173	200,479	71,806 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.267905	1,863,974	499,368 73.00
74.00	07400	RENAL DIALYSIS	0.343831	28,014	9,632 74.00
76.00	03950	ENDOSCOPY	0.164078	60,083	9,858 76.00
76.06	03330	IMAGING CENTER	0.143786	0	0 76.06
76.97	07697	CARDIAC REHABILITATION	0.316189	0	0 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	0 90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	0 90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.452630	0	0 90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0 90.03
90.04	04953	SPINE CENTER	1.171284	0	0 90.04
91.00	09100	EMERGENCY	0.109629	1,206,921	132,314 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.806331	31,296	25,235 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,107,024	1,883,913 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		10,107,024	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/30/2022 2:34 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		19,238,384	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		6,398,761	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		293,593	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		49,772	2.04
3.00	Managed Care Simulated Payments		21,692,040	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		153.83	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		7.27	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		7.27	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		7.12	10.00
11.00	FTE count for residents in dental and podiatric programs.		1.51	11.00
12.00	Current year allowable FTE (see instructions)		8.63	12.00
13.00	Total allowable FTE count for the prior year.		8.39	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		7.57	14.00
15.00	Sum of lines 12 through 14 divided by 3.		8.20	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		8.20	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.053306	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.053334	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.053306	21.00
22.00	IME payment adjustment (see instructions)		735,684	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		622,475	22.01
<b>Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		-0.15	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		735,684	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		622,475	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.07	30.00
31.00	Percentage of Medicaid patient days (see instructions)		25.25	31.00
32.00	Sum of lines 30 and 31		28.32	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.58	33.00
34.00	Disproportionate share adjustment (see instructions)		806,288	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/30/2022 2:34 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)		8,290,014,521	7,192,008,710	35.00
35.01	Factor 3 (see instructions)		0.000397191	0.000173193	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		3,292,717	1,245,606	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		2,462,771	313,961	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,776,732		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>					
40.00	Total Medicare discharges (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		30,299,214		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				<b>Amount</b>	
				<b>1.00</b>	
49.00	Total payment for inpatient operating costs (see instructions)			30,921,689	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			2,051,697	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			276,807	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			442,300	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			33,692,493	59.00
60.00	Primary payer payments			9,534	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			33,682,959	61.00
62.00	Deductibles billed to program beneficiaries			2,505,452	62.00
63.00	Coinurance billed to program beneficiaries			58,618	63.00
64.00	Allowable bad debts (see instructions)			82,955	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			53,921	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			11,960	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			31,172,810	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			-83,573	70.93
70.94	HRR adjustment amount (see instructions)			-93,055	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/30/2022 2:34 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			238,880	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			30,757,302	71.00
71.01	Sequestration adjustment (see instructions)			0	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			0	71.03
72.00	Interim payments			29,676,302	72.00
72.01	Interim payments-PARHM				72.01
73.00	Tentative settlement (for contractor use only)			0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)				73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			1,081,000	74.00
74.01	Balance due provider/program-PARHM (see instructions)				74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			608,820	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)				90.00
91.00	Capital outlier from Wkst. L, Pt. 1, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
<b>HSP Bonus Payment Amount</b>					
100.00	HSP bonus amount (see instructions)			0	100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
<b>HRR Adjustment for HSP Bonus Payment</b>					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
<b>Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment</b>					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
<b>Cost Reimbursement</b>					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. 11, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
<b>Adjustment to Medicare Part A Inpatient Reimbursement</b>					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
<b>Comparison of PPS versus Cost Reimbursement</b>					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/30/2022 2:34 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		8,369	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		16,793,693	2.00
3.00	OPPS payments		15,821,412	3.00
4.00	Outlier payment (see instructions)		76,839	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)		8,369	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		31,239	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)		31,239	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		31,239	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		22,870	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		8,369	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)		15,898,251	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,573,816	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		13,332,804	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		131,469	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		13,464,273	30.00
31.00	Primary payer payments		6,200	31.00
32.00	Subtotal (line 30 minus line 31)		13,458,073	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		184,626	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		120,007	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		161,497	36.00
37.00	Subtotal (see instructions)		13,578,080	37.00
38.00	MSP-LCC reconciliation amount from PS&R		157	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		13,577,923	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		13,723,964	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-146,041	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		5,495	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0128

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2022 2:34 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		29,676,302		13,723,964	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)		29,676,302		13,723,964	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		1,081,000		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		146,041	6.02	
7.00	Total Medicare program liability (see instructions)		30,757,302		13,577,923	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/30/2022 2:34 pm
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial /interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00



DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 5/30/2022 2:34 pm
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Title XVIII		Hospital	PPS
			1.00

COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			7.27	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			7.27	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			7.12	6.00
7.00	Enter the lesser of line 5 or line 6			7.12	7.00

		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	6.45	0.67	7.12	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	6.45	0.67	7.12	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		1.51		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		1.51		10.01
11.00	Total weighted FTE count	6.45	2.18		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	6.39	2.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	5.56	2.01		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	6.13	2.06		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	6.13	2.06		17.00
18.00	Per resident amount	97,638.76	97,638.76		18.00
19.00	Approved amount for resident costs	598,526	201,136	799,662	19.00

		Total			
		1.00			
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			799,662	25.00

		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	11,224	9,850		26.00
27.00	Total Inpatient Days (see instructions)	40,491	40,491		27.00
28.00	Ratio of inpatient days to total inpatient days	0.277197	0.243264		28.00
29.00	Program direct GME amount	221,664	194,529	416,193	29.00
29.01	Percent reduction for MA DGME		4.07		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		7,917	7,917	30.00
31.00	Net Program direct GME amount			408,276	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 5/30/2022 2:34 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)</b>				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		2,276,264	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
<b>APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY</b>				
<b>Part A Reasonable Cost</b>				
37.00	Reasonable cost (see instructions)		35,373,203	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		9,534	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		35,363,669	41.00
<b>Part B Reasonable Cost</b>				
42.00	Reasonable cost (see instructions)		16,802,062	42.00
43.00	Primary payer payments (see instructions)		6,200	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		16,795,862	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		52,159,531	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.677991	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.322009	47.00
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48.00	Total program GME payment (line 31)		408,276	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		276,807	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		131,469	50.00

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

Provider CCN: 15-0128

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

Worksheet G

Date/Time Prepared:  
5/30/2022 2:34 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	5,849	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	206,260,073	0	0	0	4.00
5.00	Other receivable	-164,146,653	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	726,418	0	0	0	6.00
7.00	Inventory	4,309,153	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	11,828	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)	47,166,668	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	1,821,632	0	0	0	12.00
13.00	Land improvements	3,022,362	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	190,935,678	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,737,035	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	86,150,931	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	24,819	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	-154,078,025	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	115,657	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	129,730,089	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	602,295,341	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	602,295,341	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	779,192,098	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	416,146	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	21,023,163	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	21,439,309	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,572,984	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,572,984	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,012,293	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	754,179,805	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	754,179,805	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	779,192,098	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0128

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

Worksheet G-1

Date/Time Prepared:  
5/30/2022 2:34 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		668,692,435		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		85,487,370			2.00
3.00	Total (sum of line 1 and line 2)		754,179,805		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		754,179,805		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		754,179,805		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0128

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/30/2022 2:34 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	124,919,359		124,919,359	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)	124,919,359		124,919,359	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	13,368,151		13,368,151	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)	13,368,151		13,368,151	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	138,287,510		138,287,510	17.00
18.00	Ancillary services	352,405,085	579,023,176	931,428,261	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	490,692,595	579,023,176	1,069,715,771	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		250,762,903		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)		250,762,903		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0128

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

Worksheet G-3

Date/Time Prepared:  
5/30/2022 2:34 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,069,715,771	1.00
2.00	Less contractual allowances and discounts on patients' accounts	745,748,214	2.00
3.00	Net patient revenues (line 1 minus line 2)	323,967,557	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	250,762,903	4.00
5.00	Net income from service to patients (line 3 minus line 4)	73,204,654	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,174	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	1,119,305	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	748,509	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	1,158,694	24.00
24.50	COVID-19 PHE Funding	9,255,034	24.50
25.00	Total other income (sum of lines 6-24)	12,282,716	25.00
26.00	Total (line 5 plus line 25)	85,487,370	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)	85,487,370	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 5/30/2022 2:34 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,964,696	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		46,135	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		112.21	3.00
4.00	Number of interns & residents (see instructions)		8.20	4.00
5.00	Indirect medical education percentage (see instructions)		2.08	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		40,866	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		2,051,697	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00