

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: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/26/2022 3:48 pm
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PART I - COST REPORT STATUS

Provider use only
 1. Electronically prepared cost report
 2. Manually prepared cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

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

Date: 5/26/2022 Time: 3:48 pm

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 IU HEALTH FRANKFORT HOSPITAL (15-1316) 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	Todd Williams	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	Todd Williams		2
3	Signatory Title	CHIEF FINANCIAL OFFICER		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	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-180,902	-1,430,454	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	-109,090	0	0	0	5.00
6.00 Swing Bed - NF	0	0	0	0	0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
200.00 Total	0	-289,992	-1,430,454	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: 15-1316			Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 3:48 pm			
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1300 SOUTH JACKSON STREET			PO Box:						1.00
2.00	City: FRANKFORT			State: IN		Zip Code: 46041		County: CLINTON		2.00
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	IU HEALTH FRANKFORT HOSPITAL	151316	99915	1	01/21/2003	N	0	0	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	IU HEALTH FRANKFORT HOSPITAL	15Z316	99915		01/21/2003	N	0	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:		To:		
						1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					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.				N	N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N				22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N		N		22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised 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: 15-1316			Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 3:48 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.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00	
						Urban/Rural S		Date of Geogr		
						1.00		2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.							2	26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.							2	27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							0	35.00	
						Beginning:		Ending:		
						1.00		2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.							0	37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00	
						Y/N		Y/N		
						1.00		2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)							N	N	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)							N	N	
						V	XVIII	XIX		
						1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)							N	N	N
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
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
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.							N	N	N
Teaching Hospitals										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.							N		
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.									
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							N		58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.							N		59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1316		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 3:48 pm	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.20
						1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00		62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00		62.01
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N		63.00
		Unweighted FTEs Nonprovi- der Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-1316

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

Worksheet S-2
Part I
Date/Time Prepared:
5/26/2022 3:48 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00		
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
				1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010									
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00		
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00		
						1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.					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			
Long Term Care Hospital PPS									
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.					N		81.00	
TEFRA Providers									
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.							86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					N		87.00	
						V	XIX		
						1.00	2.00		
Title V and XIX Services									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.					N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.					N	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.					N	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	Y	98.06	
Rural Providers									
105.00	Does this hospital qualify as a CAH?					Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					N		108.00	
						Physical	Occupational	Speech	Respiratory
						1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					Y	Y	N	N
						1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.						N		110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 3:48 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	21,848	0	118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1316		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 3:48 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: INDIANA UNIVERSITY HEALTH	Contractor's Name: WPS		Contractor's Number: 08101		141.00	
142.00	Street: 340 WEST 10TH STREET	PO Box:				142.00	
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46202		143.00	
144.00 Are provider based physicians' costs included in Worksheet A?							
						1.00	144.00
						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.							
						1.00	2.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N	146.00
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							
						1.00	147.00
						Y	
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							
						1.00	148.00
						N	
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							
						1.00	149.00
						N	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
155.00	Hospital	N	N	N	N		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC		N	N	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	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
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.						1.00	167.00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						2.00	168.00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00
						1.00	169.00
						Y	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							
						1.00	2.00
						1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					Y	42
							171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1316		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 3:48 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				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.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/01/2022	Y	04/01/2022		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 3:48 pm	
		Description	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	0	1.00	3.00	20.00
			N	N	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA		UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.962.1093		RUTTER@IUHEALTH.ORG	43.00

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	GOVERNMENT PROGRAMS DIRECTOR	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: 15-1316

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

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2022 3:48 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	12	4,380	37,128.00	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)		12	4,380	37,128.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		12	4,380	37,128.00	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	101.00				0	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)		12				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: 15-1316

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

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2022 3:48 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	633	38	1,547			1.00
2.00 HMO and other (see instructions)	404	151				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	232	0	232			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	65			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	865	38	1,844			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)	865	38	1,844	0.00	103.27	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	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	103.27	27.00
28.00 Observation Bed Days		16	378			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			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: 15-1316

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

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2022 3:48 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	200	13	496	1.00
2.00	HMO and other (see instructions)			124	57		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	200	13	496	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/26/2022 3:48 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.373074	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		3,235,528	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		17,782,008	6.00	
7.00	Medicaid cost (line 1 times line 6)		6,634,005	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)		3,398,477	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)		2,897	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		90,938	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		33,927	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)		31,030	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)		3,429,507	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)	1,642,568	136,979	1,779,547	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	612,799	136,979	749,778	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	612,799	136,979	749,778	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)		2,629,324	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		473,182	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		727,972	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		1,901,352	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		964,135	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,713,913	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,143,420	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1316

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

Worksheet A
Date/Time Prepared:
5/26/2022 3:48 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		0	0	2,171,856	2,171,856	1.00
4.00	00400	0	0	0	1,294,271	1,294,271	4.00
5.00	00500	318,957	5,876,073	6,195,030	-503,458	5,691,572	5.00
7.00	00700	481,061	1,989,772	2,470,833	-1,085,610	1,385,223	7.00
8.00	00800	0	0	0	43,237	43,237	8.00
9.00	00900	255,085	341,526	596,611	-106,447	490,164	9.00
10.00	01000	183,711	253,689	437,400	-201,337	236,063	10.00
11.00	01100	0	0	0	146,152	146,152	11.00
13.00	01300	1,182,662	284,058	1,466,720	-332,355	1,134,365	13.00
14.00	01400	80	113,616	113,696	317,400	431,096	14.00
15.00	01500	318,837	1,258,629	1,577,466	-986,384	591,082	15.00
16.00	01600	0	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,137,843	890,521	2,028,364	-365,444	1,662,920	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	305,645	1,443,167	1,748,812	-1,044,293	704,519	50.00
54.00	05400	737,480	460,753	1,198,233	-357,865	840,368	54.00
60.00	06000	0	1,567,844	1,567,844	-127,072	1,440,772	60.00
66.00	06600	0	624,204	624,204	-14,216	609,988	66.00
67.00	06700	325	211,463	211,788	-33	211,755	67.00
68.00	06800	91,024	25,457	116,481	-13,681	102,800	68.00
69.00	06900	59,146	40,992	100,138	-30,860	69,278	69.00
71.00	07100	0	0	0	66,020	66,020	71.00
72.00	07200	0	0	0	530,422	530,422	72.00
73.00	07300	0	0	0	557,021	557,021	73.00
73.01	07301	0	0	0	563,506	563,506	73.01
76.00	03160	697,311	338,583	1,035,894	-72,340	963,554	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	7,281	7,281	-7,281	0	90.00
91.00	09100	1,235,952	2,448,241	3,684,193	-441,209	3,242,984	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		7,005,119	18,175,869	25,180,988	0	25,180,988	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
192.02	19202	0	0	0	0	0	192.02
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
200.00		7,005,119	18,175,869	25,180,988	0	25,180,988	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1316

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

Worksheet A
Date/Time Prepared:
5/26/2022 3:48 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	864,273	3,036,129	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-44,340	1,249,931	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,117,348	6,808,920	5.00
7.00	00700	OPERATION OF PLANT	38,880	1,424,103	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	43,237	8.00
9.00	00900	HOUSEKEEPING	0	490,164	9.00
10.00	01000	DIETARY	0	236,063	10.00
11.00	01100	CAFETERIA	-11,126	135,026	11.00
13.00	01300	NURSING ADMINISTRATION	100,982	1,235,347	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	103,907	535,003	14.00
15.00	01500	PHARMACY	309,072	900,154	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-127,683	1,535,237	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-65,666	638,853	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	840,368	54.00
60.00	06000	LABORATORY	0	1,440,772	60.00
66.00	06600	PHYSICAL THERAPY	0	609,988	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	211,755	67.00
68.00	06800	SPEECH PATHOLOGY	0	102,800	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69,278	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	66,020	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	530,422	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	557,021	73.00
73.01	07301	ONCOLOGY DRUGS	0	563,506	73.01
76.00	03160	CARDIOPULMONARY	44,264	1,007,818	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-330,222	2,912,762	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,999,689	27,180,677	118.00
NONREIMBURSABLE COST CENTERS					
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	0	192.00
192.02	19202	MOB	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	LEASED SPACE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	1,999,689	27,180,677	200.00

RECLASSIFICATIONS

Provider CCN: 15-1316

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

Worksheet A-6

Date/Time Prepared:
5/26/2022 3:48 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA						
1.00	CAFETERIA	11.00	68,389	77,763	1.00	
	O		68,389	77,763		
B - DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00		557,021	1.00	
2.00	ONCOLOGY DRUGS	73.01		563,506	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	
	O		0	1,120,527		
C - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00		324,283	1.00	
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		66,020	2.00	
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		530,422	3.00	
4.00	ADMINISTRATIVE & GENERAL	5.00		9,353	4.00	
5.00	DIETARY	10.00		3	5.00	
6.00	RADIOLOGY-DIAGNOSTIC	54.00		2,959	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	
	O		0	933,040		
D - LAUNDRY						
1.00	LAUNDRY & LINEN SERVICE	8.00	0	43,237	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	
	O		0	43,237		
E - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,061,112	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	
	O		0	2,061,112		
F - OTHER CAPITAL						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,979	1.00	
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	20,485	2.00	
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	82,500	3.00	
4.00	OPERATION OF PLANT	7.00	0	2,932	4.00	
5.00		0.00	0	0	5.00	
	O		0	114,896		
H - EMPLOYEE BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,306,509	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	

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
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
	0		0	1,306,509	
I - HOUSEKEEPING					
1.00	HOUSEKEEPING	9.00	0	1,541	1.00
2.00	DIETARY	10.00	0	111	2.00
3.00	PHARMACY	15.00	0	99	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
	0		0	1,751	
L - ONCOLOGY					
1.00	OPERATING ROOM	50.00	0	7,281	1.00
	0		0	7,281	
M - ACCRUED PTO					
1.00	ADMINISTRATIVE & GENERAL	5.00	3,051	0	1.00
2.00	OPERATION OF PLANT	7.00	1,937	0	2.00
3.00	HOUSEKEEPING	9.00	3,003	0	3.00
4.00	NURSING ADMINISTRATION	13.00	2,637	0	4.00
5.00	PHARMACY	15.00	24,019	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	9,461	0	6.00
7.00	SPEECH PATHOLOGY	68.00	4,982	0	7.00
	0		49,090	0	
N - EMERGENCY PREP					
1.00	ADULTS & PEDIATRICS	30.00	18,886	1,488	1.00
2.00	CARDIOPULMONARY	76.00	147,105	11,588	2.00
3.00	EMERGENCY	91.00	4,098	323	3.00
	TOTALS		170,089	13,399	
500.00	Grand Total: Increases		287,568	5,679,515	500.00

RECLASSIFICATIONS

Provider CCN: 15-1316

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

Worksheet A-6

Date/Time Prepared:
5/26/2022 3:48 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	68,389	77,763	0		1.00
	O		68,389	77,763			
B - DRUGS							
1.00	CENTRAL SERVICES & SUPPLY	14.00		201	0		1.00
2.00	PHARMACY	15.00		956,351	0		2.00
3.00	ADULTS & PEDIATRICS	30.00		23,060	0		3.00
4.00	OPERATING ROOM	50.00		17,276	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00		57,891	0		5.00
6.00	LABORATORY	60.00		2	0		6.00
7.00	PHYSICAL THERAPY	66.00		926	0		7.00
8.00	ELECTROCARDIOLOGY	69.00		11	0		8.00
9.00	CARDIOPULMONARY	76.00		3,660	0		9.00
10.00	EMERGENCY	91.00		61,149	0		10.00
	O		0	1,120,527			
C - MEDICAL SUPPLIES							
1.00	OPERATION OF PLANT	7.00		22,679	0		1.00
2.00	HOUSEKEEPING	9.00		141	0		2.00
3.00	NURSING ADMINISTRATION	13.00		2,753	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00		522	0		4.00
5.00	PHARMACY	15.00		478	0		5.00
6.00	ADULTS & PEDIATRICS	30.00		54,927	0		6.00
7.00	OPERATING ROOM	50.00		650,863	0		7.00
8.00	LABORATORY	60.00		127,031	0		8.00
9.00	PHYSICAL THERAPY	66.00		4,503	0		9.00
10.00	ELECTROCARDIOLOGY	69.00		989	0		10.00
11.00	CARDIOPULMONARY	76.00		12,914	0		11.00
12.00	EMERGENCY	91.00		55,240	0		12.00
	O		0	933,040			
D - LAUNDRY							
1.00	CENTRAL SERVICES & SUPPLY	14.00		6,157	0		1.00
2.00	ADULTS & PEDIATRICS	30.00		8,112	0		2.00
3.00	OPERATING ROOM	50.00		5,798	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00		3,632	0		4.00
5.00	PHYSICAL THERAPY	66.00		2,652	0		5.00
6.00	ELECTROCARDIOLOGY	69.00		1,483	0		6.00
7.00	CARDIOPULMONARY	76.00		38	0		7.00
8.00	EMERGENCY	91.00		15,365	0		8.00
	O		0	43,237			
E - DEPRECIATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	466,904	9		1.00
2.00	OPERATION OF PLANT	7.00	0	843,306	0		2.00
3.00	DIETARY	10.00	0	6,107	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	190	0		4.00
5.00	PHARMACY	15.00	0	1,247	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	63,341	0		6.00
7.00	OPERATING ROOM	50.00	0	334,207	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	183,851	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	6,117	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	21,849	0		10.00
11.00	CARDIOPULMONARY	76.00	0	72,501	0		11.00
12.00	EMERGENCY	91.00	0	61,492	0		12.00
	O		0	2,061,112			
F - OTHER CAPITAL							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,979	11		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	20,485	12		2.00
3.00	OPERATION OF PLANT	7.00	0	82,500	10		3.00
4.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,220	13		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	1,712	0		5.00
	O		0	114,896			
H - EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,782	0		1.00
2.00	OPERATION OF PLANT	7.00	0	141,994	0		2.00
3.00	HOUSEKEEPING	9.00	0	110,850	0		3.00
4.00	DIETARY	10.00	0	44,331	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	148,555	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	3	0		6.00
7.00	PHARMACY	15.00	0	52,426	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	232,911	0		8.00
9.00	OPERATING ROOM	50.00	0	38,031	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	124,841	0		10.00
11.00	OCCUPATIONAL THERAPY	67.00	0	33	0		11.00
12.00	SPEECH PATHOLOGY	68.00	0	18,663	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	6,524	0		13.00

RECLASSIFICATIONS

Provider CCN: 15-1316

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

Worksheet A-6

Date/Time Prepared:
5/26/2022 3:48 pm

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
14.00	CARDIOPULMONARY	76.00	0	128,577	0		14.00
15.00	EMERGENCY	91.00	0	240,988	0		15.00
	O		0	1,306,509			
I - HOUSEKEEPING							
1.00	NURSING ADMINISTRATION	13.00	0	6	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	778	0		2.00
3.00	OPERATING ROOM	50.00	0	55	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	70	0		4.00
5.00	LABORATORY	60.00	0	39	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	18	0		6.00
7.00	CARDIOPULMONARY	76.00	0	73	0		7.00
8.00	EMERGENCY	91.00	0	712	0		8.00
	O		0	1,751			
L - ONCOLOGY							
1.00	CLINIC	90.00	0	7,281	0		1.00
	O		0	7,281			
M - ACCRUED PTO							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	12,238	0	0		1.00
2.00	DIETARY	10.00	4,861	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	2,689	0	0		3.00
4.00	OPERATING ROOM	50.00	5,344	0	0		4.00
5.00	ELECTROCARDIOLOGY	69.00	4	0	0		5.00
6.00	CARDIOPULMONARY	76.00	13,270	0	0		6.00
7.00	EMERGENCY	91.00	10,684	0	0		7.00
	O		49,090	0			
N - EMERGENCY PREP							
1.00	NURSING ADMINISTRATION	13.00	170,089	13,399	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		170,089	13,399			
500.00	Grand Total: Decreases		287,568	5,679,515			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1316

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

Worksheet A-7
Part I
Date/Time Prepared:
5/26/2022 3:48 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	951,047	79,086	0	79,086	0	1.00
2.00	Land Improvements	16,117	7,317	0	7,317	0	2.00
3.00	Buildings and Fixtures	35,315	26,011,944	0	26,011,944	0	3.00
4.00	Building Improvements	1,425,477	265,511	0	265,511	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	6,185,641	3,095,752	0	3,095,752	112,286	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	8,613,597	29,459,610	0	29,459,610	112,286	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	8,613,597	29,459,610	0	29,459,610	112,286	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,030,133	0				1.00
2.00	Land Improvements	23,434	0				2.00
3.00	Buildings and Fixtures	26,047,259	1,646				3.00
4.00	Building Improvements	1,690,988	117,667				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	9,169,107	2,472,436				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	37,960,921	2,591,749				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	37,960,921	2,591,749				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1316

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

Worksheet A-7
Part II
Date/Time Prepared:
5/26/2022 3:48 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
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
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1316

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

Worksheet A-7
Part III
Date/Time Prepared:
5/26/2022 3:48 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	37,960,921	0	37,960,921	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	37,960,921	0	37,960,921	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	2,005,624	82,500	1.00
3.00	Total (sum of lines 1-2)	0	0	0	2,005,624	82,500	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	928,740	20,485	-1,220	0	3,036,129	1.00
3.00	Total (sum of lines 1-2)	928,740	20,485	-1,220	0	3,036,129	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-1316

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

Worksheet A-8

Date/Time Prepared:
5/26/2022 3:48 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		
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-12,079	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-615,114			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	4,617,566			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-11,126	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts		0		0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	-117,398	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 EMPLOYEE BENEFITS	A	-1,306,509	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-1316

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

Worksheet A-8

Date/Time Prepared:
5/26/2022 3:48 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		
33.01 MEDICAID HAF FEES	A	-891,717	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 MISCELLANEOUS INCOME	B	-2,030	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 MISCELLANEOUS INCOME	B	784	PHARMACY	15.00	0	33.03
33.04 CONTRIBUTION EXPENSE	A	-951	ADULTS & PEDIATRICS	30.00	0	33.04
33.05 CONTRIBUTION EXPENSE	A	-268	OPERATION OF PLANT	7.00	0	33.05
33.06 DEPRECIATION ON CAPITALIZED ASSETS	A	61,910	CAP REL COSTS-BLDG & FIXT	1.00	9	33.06
33.07 START UP COST NEW HOSPITAL	A	276,621	ADMINISTRATIVE & GENERAL	5.00	0	33.07
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,999,689				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: 15-1316
 Period: From 01/01/2021 To 12/31/2021
 Worksheet A-8-1
 Date/Time Prepared: 5/26/2022 3:48 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5		
1.00	2.00	3.00	4.00	5.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	940,819	8,979	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,262,169	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	4,545,428	3,486,497	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	1,190,950	515,407	3.01
3.02	7.00	OPERATION OF PLANT	RELATED PARTY	99,467	60,319	3.02
4.00	13.00	NURSING ADMINISTRATION	RELATED PARTY	120,087	19,105	4.00
4.01	14.00	CENTRAL SERVICES & SUPPLY	RELATED PARTY	210,250	106,343	4.01
4.02	15.00	PHARMACY	RELATED PARTY	410,529	102,241	4.02
4.03	30.00	ADULTS & PEDIATRICS	RELATED PARTY	72,163	60,222	4.03
4.04	50.00	OPERATING ROOM	RELATED PARTY	144,868	84,308	4.04
4.05	76.00	CARDIOPULMONARY	RELATED PARTY	92,226	47,962	4.05
4.06	91.00	EMERGENCY	RELATED PARTY	63,039	43,046	4.06
4.08	10.00	DIETARY	SHARED EMPLOYEES	1,000	1,000	4.08
4.09	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	156,151	156,151	4.09
4.10	50.00	OPERATING ROOM	SHARED EMPLOYEES	159,336	159,336	4.10
4.11	60.00	LABORATORY	SHARED EMPLOYEES	1,405,256	1,405,256	4.11
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			10,873,738	6,256,172	5.00

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

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

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

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

6.00	B	IU HEALTH	100.00	0.00	6.00
7.00	B	IUH ARNETT	1.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 15-1316

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

Worksheet A-8-1

Date/Time Prepared:
5/26/2022 3:48 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	931,840	11		1.00
2.00	1,262,169	0		2.00
3.00	1,058,931	0		3.00
3.01	675,543	0		3.01
3.02	39,148	0		3.02
4.00	100,982	0		4.00
4.01	103,907	0		4.01
4.02	308,288	0		4.02
4.03	11,941	0		4.03
4.04	60,560	0		4.04
4.05	44,264	0		4.05
4.06	19,993	0		4.06
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
5.00	4,617,566			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-1316

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

Worksheet A-8-2

Date/Time Prepared:
5/26/2022 3:48 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	30.00	ADULTS & PEDIATRICS	138,673	138,673	0	0	0	1.00
2.00	50.00	OPERATING ROOM	126,226	126,226	0	0	0	2.00
3.00	91.00	EMERGENCY	1,633,715	350,215	1,283,500	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,898,614	615,114	1,283,500			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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	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	30.00	ADULTS & PEDIATRICS	0	0	0	138,673	1.00
2.00	50.00	OPERATING ROOM	0	0	0	126,226	2.00
3.00	91.00	EMERGENCY	0	0	0	350,215	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	615,114	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1316		Period: From 01/01/2021 To 12/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/26/2022 3:48 pm	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					307	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					75	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.60	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	7,267.02	487.51	536.17	0.00	9.00
10.00	AHSEA (see instructions)	0.00	87.04	56.58	33.91	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	43.52	43.52	28.29			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					632,521	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					27,583	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					660,104	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					18,182	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					678,286	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					678,286	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					13,361	24.00
25.00	Assistants (line 4 times column 3, line 11)					2,122	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					15,483	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,139	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					17,622	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					17,622	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1316				Period: From 01/01/2021 To 12/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/26/2022 3:48 pm	
		Physical Therapy				Cost			
						1.00			
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0		46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	87.04	56.58	33.91	0.00			52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00	
						1.00			
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)					678,286		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					17,622		58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0		59.00	
60.00	Overtime allowance (from column 5, line 56)					0		60.00	
61.00	Equipment cost (see instructions)					0		61.00	
62.00	Supplies (see instructions)					0		62.00	
63.00	Total allowance (sum of lines 57-62)					695,908		63.00	
64.00	Total cost of outside supplier services (from your records)					595,265		64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0		65.00	
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					15,483		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					2,139		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27					17,622		100.02	
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					2,139		101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		101.01	
101.02	Line 34 = sum of lines 27 and 31					2,139		101.02	
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0		102.01	
102.02	Line 35 = sum of lines 31 and 32					0		102.02	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1316		Period: From 01/01/2021 To 12/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/26/2022 3:48 pm	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					183	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					199	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.60	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,558.89	1,640.25	221.20	0.00	9.00
10.00	AHSEA (see instructions)	0.00	87.04	60.06	33.84	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	43.52	43.52	30.03			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					135,686	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					98,513	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					234,199	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					7,485	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					241,684	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					241,684	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					7,964	24.00
25.00	Assistants (line 4 times column 3, line 11)					5,976	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					13,940	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,139	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					16,079	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					16,079	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1316		Period: From 01/01/2021 To 12/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/26/2022 3:48 pm	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	87.04	60.06	33.84	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					241,684	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					16,079	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					257,763	63.00
64.00	Total cost of outside supplier services (from your records)					211,406	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					13,940	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					2,139	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					16,079	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					2,139	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					2,139	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1316

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2022 3:48 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,036,129	3,036,129				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,249,931	6,240	1,256,171			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,808,920	497,729	57,642	7,364,291	7,364,291	5.00
7.00 00700	OPERATION OF PLANT	1,424,103	345,716	86,461	1,856,280	689,842	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	43,237	0	0	43,237	16,068	8.00
9.00 00900	HOUSEKEEPING	490,164	67,531	46,200	603,895	224,423	9.00
10.00 01000	DIETARY	236,063	75,482	19,774	331,319	123,127	10.00
11.00 01100	CAFETERIA	135,026	46,714	12,242	193,982	72,089	11.00
13.00 01300	NURSING ADMINISTRATION	1,235,347	44,229	181,732	1,461,308	543,060	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	535,003	90,557	14	625,574	232,480	14.00
15.00 01500	PHARMACY	900,154	80,286	61,374	1,041,814	387,165	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	1,535,237	402,314	206,584	2,144,135	796,816	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	638,853	338,759	53,757	1,031,369	383,284	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	840,368	223,023	133,709	1,197,100	444,873	54.00
60.00 06000	LABORATORY	1,440,772	106,183	0	1,546,955	574,889	60.00
66.00 06600	PHYSICAL THERAPY	609,988	165,321	0	775,309	288,125	66.00
67.00 06700	OCCUPATIONAL THERAPY	211,755	9,663	58	221,476	82,306	67.00
68.00 06800	SPEECH PATHOLOGY	102,800	10,547	17,186	130,533	48,509	68.00
69.00 06900	ELECTROCARDIOLOGY	69,278	10,270	10,587	90,135	33,497	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,020	0	0	66,020	24,535	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	530,422	0	0	530,422	197,119	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	557,021	0	0	557,021	207,003	73.00
73.01 07301	ONCOLOGY DRUGS	563,506	0	0	563,506	209,413	73.01
76.00 03160	CARDIOPULMONARY	1,007,818	144,173	148,783	1,300,774	483,401	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	2,912,762	371,392	220,068	3,504,222	1,302,267	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	27,180,677	3,036,129	1,256,171	27,180,677	7,364,291	118.00
NONREIMBURSABLE COST CENTERS							
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	0	192.00
192.02 19202	MOB	0	0	0	0	0	192.02
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	LEASED SPACE	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	27,180,677	3,036,129	1,256,171	27,180,677	7,364,291	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1316

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2022 3:48 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	2,546,122				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	59,305			8.00	
9.00	00900	HOUSEKEEPING	78,640	0	906,958		9.00	
10.00	01000	DIETARY	87,899	0	32,309	574,654	10.00	
11.00	01100	CAFETERIA	54,399	0	19,995	0	340,465	11.00
13.00	01300	NURSING ADMINISTRATION	51,505	0	18,931	0	40,369	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	105,453	0	38,761	0	0	14.00
15.00	01500	PHARMACY	93,493	0	34,365	0	14,823	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	468,496	59,305	172,202	574,654	65,316	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	394,486	0	144,999	0	17,600	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	259,711	0	95,461	0	40,625	54.00
60.00	06000	LABORATORY	123,651	0	45,450	0	46,819	60.00
66.00	06600	PHYSICAL THERAPY	192,517	0	70,762	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,253	0	4,136	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,281	0	4,514	0	4,272	68.00
69.00	06900	ELECTROCARDIOLOGY	11,960	0	4,396	0	3,503	69.00
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
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	167,890	0	61,710	0	40,497	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	432,488	0	158,967	0	66,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,546,122	59,305	906,958	574,654	340,465	118.00
NONREIMBURSABLE COST CENTERS								
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	0	192.00
192.02	19202	MOB	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,546,122	59,305	906,958	574,654	340,465	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1316

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2022 3:48 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
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						11.00
13.00	01300	2,115,173					13.00
14.00	01400	0	1,002,268				14.00
15.00	01500	0	668	1,572,328			15.00
16.00	01600	0	0	0	0		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	994,902	52,187	22,710	0	5,350,723	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	194,654	97,769	15,770	0	2,279,931	50.00
54.00	05400	0	768	1,834	0	2,040,372	54.00
60.00	06000	0	137,139	0	0	2,474,903	60.00
66.00	06600	0	1,886	0	0	1,328,599	66.00
67.00	06700	0	0	0	0	319,171	67.00
68.00	06800	0	0	0	0	200,109	68.00
69.00	06900	0	1,164	0	0	144,655	69.00
71.00	07100	0	71,572	0	0	162,127	71.00
72.00	07200	0	575,025	0	0	1,302,566	72.00
73.00	07300	0	0	728,187	0	1,492,211	73.00
73.01	07301	0	0	736,665	0	1,509,584	73.01
76.00	03160	0	14,617	0	0	2,068,889	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	925,617	49,473	67,162	0	6,506,837	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		2,115,173	1,002,268	1,572,328	0	27,180,677	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
192.02	19202	0	0	0	0	0	192.02
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		2,115,173	1,002,268	1,572,328	0	27,180,677	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1316

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2022 3:48 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	5,350,723
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,279,931
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,040,372
60.00	06000	LABORATORY	0	2,474,903
66.00	06600	PHYSICAL THERAPY	0	1,328,599
67.00	06700	OCCUPATIONAL THERAPY	0	319,171
68.00	06800	SPEECH PATHOLOGY	0	200,109
69.00	06900	ELECTROCARDIOLOGY	0	144,655
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	162,127
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,302,566
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,492,211
73.01	07301	ONCOLOGY DRUGS	0	1,509,584
76.00	03160	CARDIOPULMONARY	0	2,068,889
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0
91.00	09100	EMERGENCY	0	6,506,837
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	27,180,677
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0
191.00	19100	RESEARCH	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0
192.02	19202	MOB	0	0
193.00	19300	NONPAID WORKERS	0	0
194.00	07950	LEASED SPACE	0	0
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118 through 201)	0	27,180,677

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1316

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,240	6,240	6,240		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	497,729	497,729	286	498,015	5.00
7.00 00700	OPERATION OF PLANT	0	345,716	345,716	429	46,650	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	1,087	8.00
9.00 00900	HOUSEKEEPING	0	67,531	67,531	229	15,176	9.00
10.00 01000	DIETARY	0	75,482	75,482	98	8,326	10.00
11.00 01100	CAFETERIA	0	46,714	46,714	61	4,875	11.00
13.00 01300	NURSING ADMINISTRATION	0	44,229	44,229	903	36,724	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	90,557	90,557	0	15,721	14.00
15.00 01500	PHARMACY	0	80,286	80,286	305	26,182	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	402,314	402,314	1,026	53,884	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	338,759	338,759	267	25,919	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	223,023	223,023	664	30,084	54.00
60.00 06000	LABORATORY	0	106,183	106,183	0	38,877	60.00
66.00 06600	PHYSICAL THERAPY	0	165,321	165,321	0	19,484	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	9,663	9,663	0	5,566	67.00
68.00 06800	SPEECH PATHOLOGY	0	10,547	10,547	85	3,280	68.00
69.00 06900	ELECTROCARDIOLOGY	0	10,270	10,270	53	2,265	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,659	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	13,330	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	13,998	73.00
73.01 07301	ONCOLOGY DRUGS	0	0	0	0	14,161	73.01
76.00 03160	CARDIOPULMONARY	0	144,173	144,173	739	32,690	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	371,392	371,392	1,095	88,077	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	3,036,129	3,036,129	6,240	498,015	118.00
NONREIMBURSABLE COST CENTERS							
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	0	192.00
192.02 19202	MOB	0	0	0	0	0	192.02
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	LEASED SPACE	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments			0			200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	3,036,129	3,036,129	6,240	498,015	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1316

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

Worksheet B
Part II
Date/Time Prepared:
5/26/2022 3:48 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	392,795				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,087			8.00
9.00	00900	HOUSEKEEPING	12,132	0	95,068		9.00
10.00	01000	DIETARY	13,560	0	3,387	100,853	10.00
11.00	01100	CAFETERIA	8,392	0	2,096	0	62,138
13.00	01300	NURSING ADMINISTRATION	7,946	0	1,984	0	7,368
14.00	01400	CENTRAL SERVICES & SUPPLY	16,268	0	4,063	0	0
15.00	01500	PHARMACY	14,423	0	3,602	0	2,705
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	72,276	1,087	18,050	100,853	11,921
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	60,858	0	15,199	0	3,212
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,066	0	10,006	0	7,414
60.00	06000	LABORATORY	19,076	0	4,764	0	8,545
66.00	06600	PHYSICAL THERAPY	29,700	0	7,417	0	0
67.00	06700	OCCUPATIONAL THERAPY	1,736	0	434	0	0
68.00	06800	SPEECH PATHOLOGY	1,895	0	473	0	780
69.00	06900	ELECTROCARDIOLOGY	1,845	0	461	0	639
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0
76.00	03160	CARDIOPULMONARY	25,901	0	6,469	0	7,391
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	66,721	0	16,663	0	12,163
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	392,795	1,087	95,068	100,853	62,138
NONREIMBURSABLE COST CENTERS							
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
192.02	19202	MOB	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	LEASED SPACE	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	392,795	1,087	95,068	100,853	62,138

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1316		Period: From 01/01/2021 To 12/31/2021		Worksheet B Part II Date/Time Prepared: 5/26/2022 3:48 pm	
Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
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						11.00
13.00	01300	99,154					13.00
14.00	01400	0	126,609				14.00
15.00	01500	0	84	127,587			15.00
16.00	01600	0	0	0	0		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	46,638	6,592	1,843	0	716,484	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	9,125	12,350	1,280	0	466,969	50.00
54.00	05400	0	97	149	0	311,503	54.00
60.00	06000	0	17,324	0	0	194,769	60.00
66.00	06600	0	238	0	0	222,160	66.00
67.00	06700	0	0	0	0	17,399	67.00
68.00	06800	0	0	0	0	17,060	68.00
69.00	06900	0	147	0	0	15,680	69.00
71.00	07100	0	9,041	0	0	10,700	71.00
72.00	07200	0	72,641	0	0	85,971	72.00
73.00	07300	0	0	59,089	0	73,087	73.00
73.01	07301	0	0	59,776	0	73,937	73.01
76.00	03160	0	1,846	0	0	219,209	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	43,391	6,249	5,450	0	611,201	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		99,154	126,609	127,587	0	3,036,129	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
192.02	19202	0	0	0	0	0	192.02
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		99,154	126,609	127,587	0	3,036,129	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1316

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

Worksheet B
Part II
Date/Time Prepared:
5/26/2022 3:48 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	716,484
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	466,969
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	311,503
60.00	06000	LABORATORY	0	194,769
66.00	06600	PHYSICAL THERAPY	0	222,160
67.00	06700	OCCUPATIONAL THERAPY	0	17,399
68.00	06800	SPEECH PATHOLOGY	0	17,060
69.00	06900	ELECTROCARDIOLOGY	0	15,680
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,700
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	85,971
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73,087
73.01	07301	ONCOLOGY DRUGS	0	73,937
76.00	03160	CARDIOPULMONARY	0	219,209
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0
91.00	09100	EMERGENCY	0	611,201
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,036,129
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0
191.00	19100	RESEARCH	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0
192.02	19202	MOB	0	0
193.00	19300	NONPAID WORKERS	0	0
194.00	07950	LEASED SPACE	0	0
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118 through 201)	0	3,036,129

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1316

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5A	5.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	54,985				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	113	7,017,357			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	9,014	322,008	-7,364,291	19,816,386	5.00
7.00 00700	OPERATION OF PLANT	6,261	482,998	0	1,856,280	39,597
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	43,237	0
9.00 00900	HOUSEKEEPING	1,223	258,088	0	603,895	1,223
10.00 01000	DIETARY	1,367	110,461	0	331,319	1,367
11.00 01100	CAFETERIA	846	68,389	0	193,982	846
13.00 01300	NURSING ADMINISTRATION	801	1,015,210	0	1,461,308	801
14.00 01400	CENTRAL SERVICES & SUPPLY	1,640	80	0	625,574	1,640
15.00 01500	PHARMACY	1,454	342,856	0	1,041,814	1,454
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,286	1,154,040	0	2,144,135	7,286
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	6,135	300,301	0	1,031,369	6,135
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,039	746,941	0	1,197,100	4,039
60.00 06000	LABORATORY	1,923	0	0	1,546,955	1,923
66.00 06600	PHYSICAL THERAPY	2,994	0	0	775,309	2,994
67.00 06700	OCCUPATIONAL THERAPY	175	325	0	221,476	175
68.00 06800	SPEECH PATHOLOGY	191	96,006	0	130,533	191
69.00 06900	ELECTROCARDIOLOGY	186	59,142	0	90,135	186
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	66,020	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	530,422	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	557,021	0
73.01 07301	ONCOLOGY DRUGS	0	0	0	563,506	0
76.00 03160	CARDIOPULMONARY	2,611	831,146	0	1,300,774	2,611
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	6,726	1,229,366	0	3,504,222	6,726
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	54,985	7,017,357	-7,364,291	19,816,386	39,597
NONREIMBURSABLE COST CENTERS						
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
192.02 19202	MOB	0	0	0	0	0
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	LEASED SPACE	0	0	0	0	0
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)	3,036,129	1,256,171		7,364,291	2,546,122
203.00	Unit cost multiplier (Wkst. B, Part I)	55.217405	0.179009		0.371626	64.300881
204.00	Cost to be allocated (per Wkst. B, Part II)		6,240		498,015	392,795
205.00	Unit cost multiplier (Wkst. B, Part II)		0.000889		0.025131	9.919817
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1316

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)		
		8.00	9.00	10.00	11.00	13.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
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	1,844				8.00	
9.00	00900	HOUSEKEEPING	0	38,374			9.00	
10.00	01000	DIETARY	0	1,367	1,844		10.00	
11.00	01100	CAFETERIA	0	846	0	7,970	11.00	
13.00	01300	NURSING ADMINISTRATION	0	801	0	49,181	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,640	0	0	14.00	
15.00	01500	PHARMACY	0	1,454	0	347	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,844	7,286	1,844	1,529	23,133	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	6,135	0	412	4,526	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,039	0	951	0	54.00
60.00	06000	LABORATORY	0	1,923	0	1,096	0	60.00
66.00	06600	PHYSICAL THERAPY	0	2,994	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	175	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	191	0	100	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	186	0	82	0	69.00
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
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	2,611	0	948	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	6,726	0	1,560	21,522	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,844	38,374	1,844	7,970	49,181	118.00
NONREIMBURSABLE COST CENTERS								
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	0	192.00
192.02	19202	MOB	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	59,305	906,958	574,654	340,465	2,115,173	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.161063	23.634701	311.634490	42.718319	43.007930	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,087	95,068	100,853	62,138	99,154	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.589479	2.477407	54.692516	7.796487	2.016104	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1316

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

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Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
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				11.00
13.00	01300				13.00
14.00	01400	924,523			14.00
15.00	01500	616	1,202,740		15.00
16.00	01600	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	48,139	17,372	0	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	90,185	12,063	0	50.00
54.00	05400	708	1,403	0	54.00
60.00	06000	126,501	0	0	60.00
66.00	06600	1,740	0	0	66.00
67.00	06700	0	0	0	67.00
68.00	06800	0	0	0	68.00
69.00	06900	1,074	0	0	69.00
71.00	07100	66,020	0	0	71.00
72.00	07200	530,422	0	0	72.00
73.00	07300	0	557,021	0	73.00
73.01	07301	0	563,506	0	73.01
76.00	03160	13,483	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	0	0	0	90.00
91.00	09100	45,635	51,375	0	91.00
92.00	09200				92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		924,523	1,202,740	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
191.00	19100	0	0	0	191.00
192.00	19200	0	0	0	192.00
192.02	19202	0	0	0	192.02
193.00	19300	0	0	0	193.00
194.00	07950	0	0	0	194.00
200.00					200.00
201.00					201.00
202.00		1,002,268	1,572,328	0	202.00
203.00		1.084092	1.307288	0.000000	203.00
204.00		126,609	127,587	0	204.00
205.00		0.136945	0.106080	0.000000	205.00
206.00					206.00
207.00					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1316

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

Worksheet C
Part I
Date/Time Prepared:
5/26/2022 3:48 pm

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5,350,723		5,350,723	0	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,279,931		2,279,931	0	0 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,040,372		2,040,372	0	0 54.00
60.00	06000 LABORATORY	2,474,903		2,474,903	0	0 60.00
66.00	06600 PHYSICAL THERAPY	1,328,599	0	1,328,599	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	319,171	0	319,171	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	200,109	0	200,109	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	144,655		144,655	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	162,127		162,127	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,302,566		1,302,566	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,492,211		1,492,211	0	0 73.00
73.01	07301 ONCOLOGY DRUGS	1,509,584		1,509,584	0	0 73.01
76.00	03160 CARDIOPULMONARY	2,068,889		2,068,889	0	0 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0		0	0	0 90.00
91.00	09100 EMERGENCY	6,506,837		6,506,837	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	935,047		935,047	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0		0	0	0 101.00
200.00	Subtotal (see instructions)	28,115,724	0	28,115,724	0	0 200.00
201.00	Less Observation Beds	935,047		935,047	0	0 201.00
202.00	Total (see instructions)	27,180,677	0	27,180,677	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1316

Period:
From 01/01/2021
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Worksheet C
Part I
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII		Hospital			Cost		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,821,471		3,821,471		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	25,195	6,848,018	6,873,213	0.331713	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	570,785	9,371,439	9,942,224	0.205223	54.00
60.00	06000	LABORATORY	963,120	4,115,150	5,078,270	0.487352	60.00
66.00	06600	PHYSICAL THERAPY	429,665	2,228,066	2,657,731	0.499900	66.00
67.00	06700	OCCUPATIONAL THERAPY	178,242	944,150	1,122,392	0.284367	67.00
68.00	06800	SPEECH PATHOLOGY	58,782	512,298	571,080	0.350404	68.00
69.00	06900	ELECTROCARDIOLOGY	0	780,508	780,508	0.185334	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,425	377,488	393,913	0.411581	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,151,282	2,151,282	0.605484	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,190,037	2,004,677	5,194,714	0.287256	73.00
73.01	07301	ONCOLOGY DRUGS	0	4,615,806	4,615,806	0.327047	73.01
76.00	03160	CARDIOPULMONARY	1,184,416	3,620,803	4,805,219	0.430550	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	643,093	22,085,051	22,728,144	0.286290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,820	2,116,261	2,120,081	0.441043	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
200.00		Subtotal (see instructions)	11,085,051	61,770,997	72,856,048		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	11,085,051	61,770,997	72,856,048		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/26/2022 3:48 pm
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301 ONCOLOGY DRUGS	0.000000		73.01
76.00	03160 CARDIOPULMONARY	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
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: 15-1316

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

Worksheet C
Part I
Date/Time Prepared:
5/26/2022 3:48 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5,350,723		5,350,723	0	5,350,723 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,279,931		2,279,931	0	2,279,931 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,040,372		2,040,372	0	2,040,372 54.00
60.00	06000 LABORATORY	2,474,903		2,474,903	0	2,474,903 60.00
66.00	06600 PHYSICAL THERAPY	1,328,599	0	1,328,599	0	1,328,599 66.00
67.00	06700 OCCUPATIONAL THERAPY	319,171	0	319,171	0	319,171 67.00
68.00	06800 SPEECH PATHOLOGY	200,109	0	200,109	0	200,109 68.00
69.00	06900 ELECTROCARDIOLOGY	144,655		144,655	0	144,655 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	162,127		162,127	0	162,127 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,302,566		1,302,566	0	1,302,566 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,492,211		1,492,211	0	1,492,211 73.00
73.01	07301 ONCOLOGY DRUGS	1,509,584		1,509,584	0	1,509,584 73.01
76.00	03160 CARDIOPULMONARY	2,068,889		2,068,889	0	2,068,889 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0		0	0	0 90.00
91.00	09100 EMERGENCY	6,506,837		6,506,837	0	6,506,837 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	935,047		935,047		935,047 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0		0		0 101.00
200.00	Subtotal (see instructions)	28,115,724	0	28,115,724	0	28,115,724 200.00
201.00	Less Observation Beds	935,047		935,047		935,047 201.00
202.00	Total (see instructions)	27,180,677	0	27,180,677	0	27,180,677 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1316

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

Worksheet C
Part I
Date/Time Prepared:
5/26/2022 3:48 pm

		Title XIX			Hospital	Cost	
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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,821,471		3,821,471		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	25,195	6,848,018	6,873,213	0.331713	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	570,785	9,371,439	9,942,224	0.205223	54.00
60.00	06000	LABORATORY	963,120	4,115,150	5,078,270	0.487352	60.00
66.00	06600	PHYSICAL THERAPY	429,665	2,228,066	2,657,731	0.499900	66.00
67.00	06700	OCCUPATIONAL THERAPY	178,242	944,150	1,122,392	0.284367	67.00
68.00	06800	SPEECH PATHOLOGY	58,782	512,298	571,080	0.350404	68.00
69.00	06900	ELECTROCARDIOLOGY	0	780,508	780,508	0.185334	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,425	377,488	393,913	0.411581	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,151,282	2,151,282	0.605484	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,190,037	2,004,677	5,194,714	0.287256	73.00
73.01	07301	ONCOLOGY DRUGS	0	4,615,806	4,615,806	0.327047	73.01
76.00	03160	CARDIOPULMONARY	1,184,416	3,620,803	4,805,219	0.430550	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	643,093	22,085,051	22,728,144	0.286290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,820	2,116,261	2,120,081	0.441043	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
200.00		Subtotal (see instructions)	11,085,051	61,770,997	72,856,048		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	11,085,051	61,770,997	72,856,048		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/26/2022 3:48 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301 ONCOLOGY DRUGS	0.000000		73.01
76.00	03160 CARDIOPULMONARY	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 15-1316		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part II Date/Time Prepared: 5/26/2022 3:48 pm	
Title XVIII			Hospital		Cost			
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	466,969	6,873,213	0.067940	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	311,503	9,942,224	0.031331	168,722	5,286	54.00
60.00	06000	LABORATORY	194,769	5,078,270	0.038353	289,101	11,088	60.00
66.00	06600	PHYSICAL THERAPY	222,160	2,657,731	0.083590	106,287	8,885	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,399	1,122,392	0.015502	15,237	236	67.00
68.00	06800	SPEECH PATHOLOGY	17,060	571,080	0.029873	26,068	779	68.00
69.00	06900	ELECTROCARDIOLOGY	15,680	780,508	0.020089	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,700	393,913	0.027163	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	85,971	2,151,282	0.039963	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,087	5,194,714	0.014069	862,267	12,131	73.00
73.01	07301	ONCOLOGY DRUGS	73,937	4,615,806	0.016018	0	0	73.01
76.00	03160	CARDIOPULMONARY	219,209	4,805,219	0.045619	417,099	19,028	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	611,201	22,728,144	0.026892	16,168	435	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	125,207	2,120,081	0.059058	0	0	92.00
200.00		Total (lines 50 through 199)	2,444,852	69,034,577		1,900,949	57,868	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/26/2022 3:48 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	Cost		
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	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: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/26/2022 3:48 pm
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)			
	4.00	5.00	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	6,873,213	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,942,224	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	5,078,270	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,657,731	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,122,392	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	571,080	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	780,508	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	393,913	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,151,282	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,194,714	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	4,615,806	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	4,805,219	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	22,728,144	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,120,081	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	69,034,577		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/26/2022 3:48 pm
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Cost Center Description		Title XVIII			Hospital		Cost
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	168,722	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	289,101	0	0	0	60.00
66.00	06600 PHYSICAL THERAPY	0.000000	106,287	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	15,237	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	26,068	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	862,267	0	0	0	73.00
73.01	07301 ONCOLOGY DRUGS	0.000000	0	0	0	0	73.01
76.00	03160 CARDIOPULMONARY	0.000000	417,099	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	16,168	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00	Total (Lines 50 through 199)		1,900,949	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/26/2022 3:48 pm
Title XVIII		Hospital	Cost

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
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.331713	0	1,522,263	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.205223	0	1,696,006	0	0
60.00 06000 LABORATORY	0.487352	0	627,277	0	0
66.00 06600 PHYSICAL THERAPY	0.499900	0	574,559	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.284367	0	244,600	0	0
68.00 06800 SPEECH PATHOLOGY	0.350404	0	63,280	0	0
69.00 06900 ELECTROCARDIOLOGY	0.185334	0	203,553	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.411581	0	64,095	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.605484	0	633,131	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.287256	0	360,131	149	0
73.01 07301 ONCOLOGY DRUGS	0.327047	0	1,817,920	0	0
76.00 03160 CARDIOPULMONARY	0.430550	0	938,675	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.000000	0	0	0	0
91.00 09100 EMERGENCY	0.286290	0	3,606,896	79,796	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.441043	0	528,529	0	0
200.00 Subtotal (see instructions)		0	12,880,915	79,945	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 - line 201)		0	12,880,915	79,945	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/26/2022 3:48 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	504,954	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	348,059	0	54.00
60.00	06000	LABORATORY	305,705	0	60.00
66.00	06600	PHYSICAL THERAPY	287,222	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	69,556	0	67.00
68.00	06800	SPEECH PATHOLOGY	22,174	0	68.00
69.00	06900	ELECTROCARDIOLOGY	37,725	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,380	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	383,351	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	103,450	43	73.00
73.01	07301	ONCOLOGY DRUGS	594,545	0	73.01
76.00	03160	CARDIOPULMONARY	404,147	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	1,032,618	22,845	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	233,104	0	92.00
200.00		Subtotal (see instructions)	4,352,990	22,888	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	4,352,990	22,888	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/26/2022 3:48 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,222 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,925 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,547 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			232 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			65 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)			633 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)			232 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			231.10 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			5,350,723 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)			15,022 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)			588,913 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			4,761,810 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			4,761,810 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			2,473.67 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,565,833 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,565,833 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/26/2022 3:48 pm		
Cost Center Description			Title XVIII		Hospital		
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
			1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					674,022	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,239,855	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					573,891	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)					573,891	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)					378	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,473.67	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					935,047	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1316		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/26/2022 3:48 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)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	716,484	5,350,723	0.133904	935,047	125,207	90.00
91.00	Nursing Program cost	0	5,350,723	0.000000	935,047	0	91.00
92.00	Allied health cost	0	5,350,723	0.000000	935,047	0	92.00
93.00	All other Medical Education	0	5,350,723	0.000000	935,047	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/26/2022 3:48 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,222	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,925	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,547	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		232	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		65	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)		38	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,350,723	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)		15,022	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)		588,913	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,761,810	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,761,810	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		2,473.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		93,999	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)		93,999	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1316		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1	
		Title XIX		Hospital		Date/Time Prepared: 5/26/2022 3:48 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)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					66,629	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					160,628	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					378	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,473.67	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					935,047	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1316

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

Worksheet D-1
Date/Time Prepared:
5/26/2022 3:48 pm

Cost Center Description	Cost	Title XIX		Hospital	Cost	
		Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	716,484	5,350,723	0.133904	935,047	125,207	90.00
91.00 Nursing Program cost	0	5,350,723	0.000000	935,047	0	91.00
92.00 Allied health cost	0	5,350,723	0.000000	935,047	0	92.00
93.00 All other Medical Education	0	5,350,723	0.000000	935,047	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/26/2022 3:48 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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,390,224		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.331713	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.205223	168,722	34,626	54.00
60.00	06000 LABORATORY	0.487352	289,101	140,894	60.00
66.00	06600 PHYSICAL THERAPY	0.499900	106,287	53,133	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.284367	15,237	4,333	67.00
68.00	06800 SPEECH PATHOLOGY	0.350404	26,068	9,134	68.00
69.00	06900 ELECTROCARDIOLOGY	0.185334	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.411581	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.605484	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.287256	862,267	247,691	73.00
73.01	07301 ONCOLOGY DRUGS	0.327047	0	0	73.01
76.00	03160 CARDIOPULMONARY	0.430550	417,099	179,582	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.286290	16,168	4,629	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.441043	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,900,949	674,022	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,900,949		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1316 Component CCN: 15-Z316	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/26/2022 3:48 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.331713	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.205223	12,963	2,660	54.00
60.00	06000 LABORATORY	0.487352	36,703	17,887	60.00
66.00	06600 PHYSICAL THERAPY	0.499900	202,687	101,323	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.284367	116,377	33,094	67.00
68.00	06800 SPEECH PATHOLOGY	0.350404	6,423	2,251	68.00
69.00	06900 ELECTROCARDIOLOGY	0.185334	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.411581	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.605484	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.287256	95,268	27,366	73.00
73.01	07301 ONCOLOGY DRUGS	0.327047	0	0	73.01
76.00	03160 CARDIOPULMONARY	0.430550	16,413	7,067	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.286290	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.441043	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		486,834	191,648	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)		486,834		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/26/2022 3:48 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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		83,469		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.331713	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.205223	25,866	5,308	54.00
60.00	06000 LABORATORY	0.487352	28,382	13,832	60.00
66.00	06600 PHYSICAL THERAPY	0.499900	1,700	850	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.284367	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.350404	1,681	589	68.00
69.00	06900 ELECTROCARDIOLOGY	0.185334	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.411581	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.605484	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.287256	58,170	16,710	73.00
73.01	07301 ONCOLOGY DRUGS	0.327047	0	0	73.01
76.00	03160 CARDIOPULMONARY	0.430550	28,324	12,195	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.286290	59,886	17,145	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.441043	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		204,009	66,629	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)		204,009		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 3:48 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,375,878 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	OPPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4,375,878 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			4,419,637 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			14,658 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			2,305,272 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)			2,099,707 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,099,707 30.00
31.00	Primary payer payments			4,276 31.00
32.00	Subtotal (line 30 minus line 31)			2,095,431 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			703,343 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			457,173 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			544,520 36.00
37.00	Subtotal (see instructions)			2,552,604 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			2,552,604 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			3,983,058 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)			-1,430,454 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			256,634 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1316

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

Worksheet E-1
Part I
Date/Time Prepared:
5/26/2022 3:48 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,902,077		3,651,758	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	12/14/2021	336,200	12/14/2021	331,300	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)		336,200		331,300	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)		2,238,277		3,983,058	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		180,902		1,430,454	6.02	
7.00	Total Medicare program liability (see instructions)		2,057,375		2,552,604	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1316
Component CCN: 15-Z316

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

Worksheet E-1
Part I
Date/Time Prepared:
5/26/2022 3:48 pm

		Title XVIII		Swing Beds - SNF		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		743,700		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	12/14/2021	137,100		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)		137,100		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)		880,800		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		109,090		0	6.02	
7.00	Total Medicare program liability (see instructions)		771,710		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/26/2022 3:48 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (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
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial /interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet E-2
		Component CCN: 15-Z316		Date/Time Prepared: 5/26/2022 3:48 pm
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	579,630	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	193,564	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	232	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	773,194	0	8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	773,194	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	773,194	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	1,484	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	771,710	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	771,710	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	880,800	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	-109,090	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	44,529	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1316	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prepared: 5/26/2022 3:48 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			2,239,855 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			2,239,855 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,262,254 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,262,254 19.00
20.00	Deductibles (exclude professional component)			220,888 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			2,041,366 22.00
23.00	Coinurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			2,041,366 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			24,629 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			16,009 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			7,936 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,057,375 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.98	Recovery of accelerated depreciation.			0 29.98
29.99	Demonstration payment adjustment amount before sequestration			0 29.99
30.00	Subtotal (see instructions)			2,057,375 30.00
30.01	Sequestration adjustment (see instructions)			0 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
30.03	Sequestration adjustment-PARHM			0 30.03
31.00	Interim payments			2,238,277 31.00
31.01	Interim payments-PARHM			0 31.01
32.00	Tentative settlement (for contractor use only)			0 32.00
32.01	Tentative settlement-PARHM (for contractor use only)			0 32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)			-180,902 33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			0 33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			130,266 34.00

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

Provider CCN: 15-1316

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

Worksheet G

Date/Time Prepared:
5/26/2022 3:48 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-12,969,049	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	3,254,106	0	0	0	4.00
5.00	Other receivable	3,796,432	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	327,560	0	0	0	7.00
8.00	Prepaid expenses	49,735	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	-5,541,216	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,030,133	0	0	0	12.00
13.00	Land improvements	23,434	0	0	0	13.00
14.00	Accumulated depreciation	-6,640	0	0	0	14.00
15.00	Buildings	26,047,259	0	0	0	15.00
16.00	Accumulated depreciation	-895,362	0	0	0	16.00
17.00	Leasehold improvements	762,337	0	0	0	17.00
18.00	Accumulated depreciation	-477,179	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	9,380,671	0	0	0	23.00
24.00	Accumulated depreciation	-5,632,274	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	30,232,379	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,492,188	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,492,188	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	26,183,351	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,535,779	0	0	0	37.00
38.00	Salaries, wages, and fees payable	430,435	0	0	0	38.00
39.00	Payroll taxes payable	32,707	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	703,286	0	0	0	42.00
43.00	Due to other funds	6,823,085	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,525,292	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	20,973,417	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	20,973,417	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	32,498,709	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-6,315,358	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)	-6,315,358	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	26,183,351	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1316

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

Worksheet G-1

Date/Time Prepared:
5/26/2022 3:48 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		-13,840,147		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		7,524,790				2.00
3.00	Total (sum of line 1 and line 2)		-6,315,357		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-6,315,357		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ROUNDING	1		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-6,315,358		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	ROUNDING		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: 15-1316

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/26/2022 3:48 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,556,560		3,556,560	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	264,911		264,911	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)	3,821,471		3,821,471	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,821,471		3,821,471	17.00
18.00	Ancillary services	6,616,667	37,569,685	44,186,352	18.00
19.00	Outpatient services	646,913	24,201,312	24,848,225	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,085,051	61,770,997	72,856,048	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,180,988		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)		25,180,988		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-1316

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

Worksheet G-3

Date/Time Prepared:
5/26/2022 3:48 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	72,856,048	1.00
2.00	Less contractual allowances and discounts on patients' accounts	44,516,101	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,339,947	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,180,988	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,158,959	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	318,064	24.00
24.50	COVID-19 PHE Funding	4,047,767	24.50
25.00	Total other income (sum of lines 6-24)	4,365,831	25.00
26.00	Total (line 5 plus line 25)	7,524,790	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	7,524,790	29.00