

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: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/23/2021 10:33 am
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/23/2021 Time: 10:33 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. MARY MEDICAL CENTER, INC. ( 15-0034 ) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) MARY F. SUDICKY  
Officer or Administrator of Provider(s)

VP OF FINANCE/CFO  
Title

(Dated when report is electronically signed.)  
Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	393,775	11,951	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	80,115	0	0	0	3.00
5.00 Swing Bed - SNF	0	0	0	0	0	5.00
6.00 Swing Bed - NF	0	0	0	0	0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
200.00 Total	0	473,890	11,951	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: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 10:33 am
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1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1500 SOUTH LAKE AVENUE			PO Box:		Date Certified		Payment System (P, T, O, or N)		1.00	
2.00	City: HOBART			State: IN		Zip Code: 46342		County: LAKE		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		ST. MARY MEDICAL CENTER, INC.	150034	23844	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF		SMMC REHABILITATION UNIT	15T034	23844	5	01/01/2001	N	P	P	4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF		10.00								
11.00	Hospital-Based OLTC		11.00								
12.00	Hospital-Based HHA		SMMC HOME HEALTH AGENCY	157313	23844		02/08/1996	N	P	N	12.00
13.00	Separately Certified ASC		13.00								
14.00	Hospital-Based Hospice		14.00								
15.00	Hospital-Based Health Clinic - RHC		15.00								
16.00	Hospital-Based Health Clinic - FQHC		16.00								
17.00	Hospital-Based (CMHC) I		17.00								
18.00	Renal Dialysis		18.00								
19.00	Other		19.00								
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2020	06/30/2021			20.00	
21.00	Type of Control (see instructions)					2				21.00	
						1.00	2.00	3.00			

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0034			Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 10:33 am		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,049	139	39	117	5,411	110	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.	44	0	0	0	469		25.00	
						Urban/Rural	S	Date of Geogr	
						1.00		2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:		Ending:	
						1.00		2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N		Y/N	
						1.00		2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
<b>Prospective Payment System (PPS)-Capital</b>									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)					N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
<b>Teaching Hospitals</b>									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00

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		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

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

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

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

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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
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
			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		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 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

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			1.00	2.00	3.00
<b>Inpatient Psychiatric Facility PPS</b>					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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
<b>Inpatient Rehabilitation Facility PPS</b>					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00
			1.00		
<b>Long Term Care Hospital PPS</b>					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N			80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N			81.00
<b>TEFRA Providers</b>					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
			V	XIX	
			1.00	2.00	
<b>Title V and XIX Services</b>					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.06
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 10:33 am
			V 1.00	XIX 2.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
		Physical 1.00	Occupational 2.00	Speech 3.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N
				1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110.00
			1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
			1.00	2.00
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.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00
118.01	List amounts of malpractice premiums and paid losses:	1	0	0
			1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		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
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0034		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 10:33 am	
		1.00	2.00				
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	Removed and reserved						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H054				140.00
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: COMMUNITY FOUNDATION OF NW IN, INC.	Contractor's Name: WPS		Contractor's Number: 08001			141.00
142.00	Street: STREET: STREET: 10010 DONALD POWER	PO Box: 201					142.00
143.00	City: MUNSTER	State: IN		Zip Code: 46321			143.00
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y				144.00
				1.00	2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y	N				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N					146.00
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		Y				147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N				148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N				149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N		155.00
156.00	Subprovider - IPF	N	N	N	N		156.00
157.00	Subprovider - IRF	N	N	N	N		157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N		159.00
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00
161.00	CMHC		N	N	N		161.00
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N		165.00
		Name	County	State	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
							1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					9.99	169.00



HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 10:33 am
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0034		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part II Date/Time Prepared: 11/23/2021 10:33 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date			V/I	
		1.00	2.00			3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type			Date	
		1.00	2.00			3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	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	09/28/2021	Y	09/28/2021		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: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/23/2021 10:33 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00		2.00	
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CATHERINE		WOERNER	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	12197031267		CATHERINE.R.WOERNER@COMHS.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0034

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
11/23/2021 10:33 am

		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT SUPERVISOR	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: 15-0034

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/23/2021 10:33 am

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	160	58,400	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		160	58,400	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	20	7,300	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		180	65,700	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	20	7,300		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						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)		200				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: 15-0034

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/23/2021 10:33 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents			
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	15,204	933	36,121			1.00
2.00	HMO and other (see instructions)	11,411	5,706				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	698	469				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	15,204	933	36,121			7.00
8.00	INTENSIVE CARE UNIT	1,795	18	5,136			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		98	1,434			13.00
14.00	Total (see instructions)	16,999	1,049	42,691	0.00	1,091.87	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	3,441	44	5,437	0.00	27.84	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	12,274	0	24,672	0.00	27.34	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			3			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	1,147.05	27.00
28.00	Observation Bed Days		0	5,096			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	110	229			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: 15-0034

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/23/2021 10:33 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,476	201	8,567	1.00
2.00 HMO and other (see instructions)			1,801	1,153		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				37		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	3,476	201	8,567	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	322	4	488	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 WAGE INDEX INFORMATION

Provider CCN: 15-0034

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
11/23/2021 10:33 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	76,001,850	0	76,001,850	2,385,864.22	31.86
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		171,380	0	171,380	3,588.00	47.76
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		4,441,177	0	4,441,177	123,297.00	36.02
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		4,398,009	0	4,398,009	86,231.14	51.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		700,247	0	700,247	4,435.34	157.88
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		10,443,308	0	10,443,308	290,538.00	35.94
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		19,870,044	0	19,870,044		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,153,780	0	1,153,780		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		39,087	0	39,087		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		2,655,503	0	2,655,503		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		



HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0034

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
11/23/2021 10:33 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)	0	0	0			25.53
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	537,517	0	537,517	16,084.00	33.42	26.00
27.00	Administrative & General	8,864,603	0	8,864,603	281,535.00	31.49	27.00
28.00	Administrative & General under contract (see inst.)	1,366,297	0	1,366,297	11,752.10	116.26	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	2,228,409	0	2,228,409	67,441.00	33.04	30.00
31.00	Laundry & Linen Service	88,263	0	88,263	5,688.00	15.52	31.00
32.00	Housekeeping	1,981,118	0	1,981,118	120,574.00	16.43	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	1,941,302	-687,749	1,253,553	70,193.00	17.86	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	687,749	687,749	38,510.00	17.86	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	3,493,889	0	3,493,889	93,972.00	37.18	38.00
39.00	Central Services and Supply	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0034

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
11/23/2021 10:33 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	77,196,767	0	77,196,767	2,394,028.32	32.25	1.00
2.00	Excluded area salaries (see instructions)	4,441,177	0	4,441,177	123,297.00	36.02	2.00
3.00	Subtotal salaries (line 1 minus line 2)	72,755,590	0	72,755,590	2,270,731.32	32.04	3.00
4.00	Subtotal other wages & related costs (see inst.)	15,541,564	0	15,541,564	381,204.48	40.77	4.00
5.00	Subtotal wage-related costs (see inst.)	22,525,547	0	22,525,547	0.00	30.96	5.00
6.00	Total (sum of lines 3 thru 5)	110,822,701	0	110,822,701	2,651,935.80	41.79	6.00
7.00	Total overhead cost (see instructions)	20,501,398	0	20,501,398	705,749.10	29.05	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 11/23/2021 10:33 am
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		2,384,880	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		11,313,385	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		669,538	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		58,007	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		53,753	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		888,151	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		4,449,698	17.00
18.00	Medicare Taxes - Employers Portion Only		1,052,088	18.00
19.00	Unemployment Insurance		193,411	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		21,062,911	24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part V Date/Time Prepared: 11/23/2021 10:33 am
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	4,398,009	21,062,911	1.00
2.00	Hospital	4,398,009	19,870,044	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	451,854	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	627,933	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	113,080	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 15-0034 Component CCN: 15-7313		Period: From 07/01/2020 To 06/30/2021		Worksheet S-4 Date/Time Prepared: 11/23/2021 10:33 am PPS	
				Home Health Agency I			
				1.00			
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	1,187	0	939	2,126	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	595.00	0.00	834.00	1,429.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.02	0.00	1.02	4.00
5.00	Other Administrative Personnel			10.67	0.00	10.67	5.00
6.00	Direct Nursing Service			7.10	0.00	7.10	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			2.63	0.02	2.65	8.00
9.00	Physical Therapy Supervisor			1.09	0.00	1.09	9.00
10.00	Occupational Therapy Service			1.08	0.12	1.20	10.00
11.00	Occupational Therapy Supervisor			0.46	0.00	0.46	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.30	0.00	0.30	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			3.06	0.00	3.06	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	MONITORING			0.00	0.01	0.01	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	23844					20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	4,181	1,493	127	19	5,820	21.00
22.00	Skilled Nursing Visit Charges	840,075	302,906	25,571	3,775	1,172,327	22.00
23.00	Physical Therapy Visits	2,255	1,218	25	11	3,509	23.00
24.00	Physical Therapy Visit Charges	529,760	285,740	5,840	2,570	823,910	24.00
25.00	Occupational Therapy Visits	636	900	10	5	1,551	25.00
26.00	Occupational Therapy Visit Charges	149,470	211,090	2,370	1,160	364,090	26.00
27.00	Speech Pathology Visits	82	122	3	0	207	27.00
28.00	Speech Pathology Visit Charges	19,220	28,810	690	0	48,720	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	596	584	3	4	1,187	31.00
32.00	Home Health Aide Visit Charges	89,916	88,088	457	588	179,049	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	7,750	4,317	168	39	12,274	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,628,441	916,634	34,928	8,093	2,588,096	35.00
36.00	Total Number of Episodes (standard/non outlier)	799		114	6	919	36.00
37.00	Total Number of Outlier Episodes		186		1	187	37.00
38.00	Total Non-Routine Medical Supply Charges	153,874	35,875	4,309	0	194,058	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/23/2021 10:33 am
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.191914	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		16,585,593	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		150,364,460	6.00	
7.00	Medicaid cost (line 1 times line 6)		28,857,045	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)		12,271,452	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		12,271,452	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)	6,639,325	628,551	7,267,876	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,274,179	628,551	1,902,730	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,274,179	628,551	1,902,730	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)			8,573,465	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			628,249	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			966,536	27.01
28.00	Non-Medicare bad debt expense (see instructions)			7,606,929	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,798,163	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			3,700,893	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			15,972,345	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0034

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

Worksheet A

Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		9,548,128	9,548,128	182,087	9,730,215	1.00
2.00	00200		8,257,207	8,257,207	21,798	8,279,005	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	537,517	11,980,920	12,518,437	-245	12,518,192	4.00
5.01	00560	376,299	99,891	476,190	-267	475,923	5.01
5.02	00570	2,300,847	362,946	2,663,793	-252	2,663,541	5.02
5.03	00580	0	10	10	0	10	5.03
5.04	00590	6,187,457	51,820,937	58,008,394	-555,944	57,452,450	5.04
7.00	00700	2,228,409	7,206,350	9,434,759	3,925	9,438,684	7.00
8.00	00800	88,263	881,998	970,261	0	970,261	8.00
9.00	00900	1,981,118	769,678	2,750,796	4,974	2,755,770	9.00
10.00	01000	1,941,302	1,380,132	3,321,434	-1,176,691	2,144,743	10.00
11.00	01100	0	0	0	1,176,691	1,176,691	11.00
13.00	01300	3,493,889	2,887,786	6,381,675	56,379	6,438,054	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	273,643	105,683	379,326	0	379,326	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	13,825,535	3,331,745	17,157,280	623,200	17,780,480	30.00
31.00	03100	3,791,721	1,202,756	4,994,477	3,425	4,997,902	31.00
41.00	04100	1,739,296	1,234,312	2,973,608	-23	2,973,585	41.00
43.00	04300	0	0	0	1,507,690	1,507,690	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	6,598,256	14,955,354	21,553,610	437,319	21,990,929	50.00
51.00	05100	2,811,016	677,131	3,488,147	0	3,488,147	51.00
52.00	05200	2,332,977	951,648	3,284,625	-2,045,217	1,239,408	52.00
53.00	05300	0	4,010,655	4,010,655	0	4,010,655	53.00
54.00	05400	3,166,351	1,932,447	5,098,798	-3,026	5,095,772	54.00
55.00	05500	527,538	683,749	1,211,287	-300	1,210,987	55.00
56.00	05600	519,284	926,038	1,445,322	0	1,445,322	56.00
57.00	05700	1,004,382	1,054,503	2,058,885	0	2,058,885	57.00
58.00	05800	527,727	697,287	1,225,014	0	1,225,014	58.00
59.00	05900	1,575,454	1,411,555	2,987,009	412,328	3,399,337	59.00
60.00	06000	3,662,627	7,543,728	11,206,355	84,115	11,290,470	60.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	154,004	1,187,786	1,341,790	0	1,341,790	63.00
64.00	06400	376,045	144,704	520,749	0	520,749	64.00
65.00	06500	2,091,965	638,548	2,730,513	36,854	2,767,367	65.00
66.00	06600	8,025	3,291,385	3,299,410	0	3,299,410	66.00
67.00	06700	984	999,388	1,000,372	0	1,000,372	67.00
68.00	06800	0	486,323	486,323	0	486,323	68.00
69.00	06900	855,385	334,452	1,189,837	0	1,189,837	69.00
70.00	07000	414,480	157,111	571,591	0	571,591	70.00
71.00	07100	0	9,278,904	9,278,904	-326,592	8,952,312	71.00
72.00	07200	0	12,986,172	12,986,172	-532,944	12,453,228	72.00
73.00	07300	2,350,808	15,063,211	17,414,019	65	17,414,084	73.00
74.00	07400	0	834,241	834,241	0	834,241	74.00
76.97	07697	478,263	112,241	590,504	0	590,504	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	1,132,662	1,006,561	2,139,223	-282	2,138,941	90.00
91.00	09100	4,220,083	1,765,021	5,985,104	4,627	5,989,731	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	2,417,067	554,045	2,971,112	-135	2,970,977	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		75,990,679	184,754,667	260,745,346	-86,441	260,658,905	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	11,171	1,425	12,596	0	12,596	191.00
192.00	19200	0	8,833	8,833	0	8,833	192.00
194.00	07950	0	718,324	718,324	0	718,324	194.00
194.01	07952	0	129,810	129,810	86,441	216,251	194.01
200.00		76,001,850	185,613,059	261,614,909	0	261,614,909	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0034

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

Worksheet A  
Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-528,928	9,201,287	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,108,857	9,387,862	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,505,162	14,023,354	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	475,923	5.01
5.02	00570	ADMINISTRATIVE	0	2,663,541	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,988,167	2,988,177	5.03
5.04	00590	OTHER ADMINISTRATIVE & GENERAL	-29,780,681	27,671,769	5.04
7.00	00700	OPERATION OF PLANT	0	9,438,684	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	970,261	8.00
9.00	00900	HOUSEKEEPING	0	2,755,770	9.00
10.00	01000	DIETARY	-290	2,144,453	10.00
11.00	01100	CAFETERIA	-865,704	310,987	11.00
13.00	01300	NURSING ADMINISTRATION	-2,003,534	4,434,520	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,535,834	2,535,834	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	-37,474	341,852	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-16,064	17,764,416	30.00
31.00	03100	INTENSIVE CARE UNIT	-6,711	4,991,191	31.00
41.00	04100	SUBPROVIDER - IRF	-11	2,973,574	41.00
43.00	04300	NURSERY	0	1,507,690	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-18,137	21,972,792	50.00
51.00	05100	RECOVERY ROOM	-2	3,488,145	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-316,268	923,140	52.00
53.00	05300	ANESTHESIOLOGY	-3,551,473	459,182	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-16,214	5,079,558	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	1,210,987	55.00
56.00	05600	RADIOISOTOPE	0	1,445,322	56.00
57.00	05700	CT SCAN	-1,350	2,057,535	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,225,014	58.00
59.00	05900	CARDIAC CATHETERIZATION	-6,912	3,392,425	59.00
60.00	06000	LABORATORY	-209,238	11,081,232	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
63.00	06300	BLOOD STORAGE, PROCESSING, & TRANS.	0	1,341,790	63.00
64.00	06400	INTRAVENOUS THERAPY	0	520,749	64.00
65.00	06500	RESPIRATORY THERAPY	-13,393	2,753,974	65.00
66.00	06600	PHYSICAL THERAPY	0	3,299,410	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,000,372	67.00
68.00	06800	SPEECH PATHOLOGY	0	486,323	68.00
69.00	06900	ELECTROCARDIOLOGY	-2,065	1,187,772	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-3,398	568,193	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,952,312	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,453,228	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-477,200	16,936,884	73.00
74.00	07400	RENAL DIALYSIS	0	834,241	74.00
76.97	07697	CARDIAC REHABILITATION	-31,375	559,129	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	-216,258	1,922,683	90.00
91.00	09100	EMERGENCY	-311	5,989,420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	HOME HEALTH AGENCY	-485	2,970,492	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-29,965,456	230,693,449	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	12,596	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,833	192.00
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER	0	718,324	194.00
194.01	07952	ADVERTISING	0	216,251	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-29,965,456	231,649,453	200.00



RECLASSIFICATIONS

Provider CCN: 15-0034

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

Worksheet A-6

Date/Time Prepared:  
11/23/2021 10:33 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - RECLASS PROPERTY INSURANCE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	182,087	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13,193	2.00
	TOTALS		0	195,280	
<b>B - CAFETERIA EXPENSES RECLASS</b>					
1.00	CAFETERIA	11.00	687,749	488,942	1.00
	TOTALS		687,749	488,942	
<b>C - RECLASS LDRP COSTS</b>					
1.00	ADULTS & PEDIATRICS	30.00	381,782	155,733	1.00
2.00	NURSERY	43.00	1,070,870	436,820	2.00
	TOTALS		1,452,652	592,553	
<b>D - RECLASS COVID COSTS</b>					
1.00	OPERATION OF PLANT	7.00	0	5,161	1.00
2.00	HOUSEKEEPING	9.00	0	4,974	2.00
3.00	NURSING ADMINISTRATION	13.00	0	56,379	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	87,458	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	3,425	5.00
6.00	OPERATING ROOM	50.00	0	1,041	6.00
7.00	LABORATORY	60.00	0	84,115	7.00
8.00	RESPIRATORY THERAPY	65.00	0	36,854	8.00
9.00	EMERGENCY	91.00	0	4,812	9.00
10.00	HOME HEALTH AGENCY	101.00	0	1,056	10.00
	TOTALS		0	285,275	
<b>E - INTEREST EXPENSE RECLASS</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,605	1.00
	TOTALS		0	8,605	
<b>F - INVENTORY ADJUSTMENT</b>					
1.00	OPERATING ROOM	50.00	0	447,208	1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	412,328	2.00
	TOTALS		0	859,536	
<b>G - ADVERTISING NONREIMBURSABLE</b>					
1.00	ADVERTISING	194.01	0	86,441	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	65	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	TOTALS		0	86,506	
500.00	Grand Total: Increases		2,140,401	2,516,697	500.00

RECLASSIFICATIONS

Provider CCN: 15-0034

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

Worksheet A-6

Date/Time Prepared:  
11/23/2021 10:33 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - RECLASS PROPERTY INSURANCE</b>							
1.00	OTHER ADMINISTRATIVE & GENERAL	5.04	0	195,280	12		1.00
2.00		0.00	0	0	12		2.00
	<b>TOTALS</b>		0	195,280			
<b>B - CAFETERIA EXPENSES RECLASS</b>							
1.00	DIETARY	10.00	687,749	488,942	0		1.00
	<b>TOTALS</b>		687,749	488,942			
<b>C - RECLASS LDRP COSTS</b>							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1,452,652	592,553	0		1.00
2.00		0.00	0	0	0		2.00
	<b>TOTALS</b>		1,452,652	592,553			
<b>D - RECLASS COVID COSTS</b>							
1.00	OTHER ADMINISTRATIVE & GENERAL	5.04	0	285,275	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
	<b>TOTALS</b>		0	285,275			
<b>E - INTEREST EXPENSE RECLASS</b>							
1.00	OPERATING ROOM	50.00	0	8,605	11		1.00
	<b>TOTALS</b>		0	8,605			
<b>F - INVENTORY ADJUSTMENT</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	326,592	0		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	532,944	0		2.00
	<b>TOTALS</b>		0	859,536			
<b>G - ADVERTISING NONREIMBURSABLE</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	245	0		1.00
2.00	PURCHASING RECEIVING AND STORES	5.01	0	267	0		2.00
3.00	ADMINISTRATIVE	5.02	0	252	0		3.00
4.00	OTHER ADMINISTRATIVE & GENERAL	5.04	0	75,389	0		4.00
5.00	OPERATION OF PLANT	7.00	0	1,236	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	1,773	0		6.00
7.00	SUBPROVIDER - IRF	41.00	0	23	0		7.00
8.00	OPERATING ROOM	50.00	0	2,325	0		8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	12	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,026	0		10.00
11.00	RADIOLOGY - THERAPEUTIC	55.00	0	300	0		11.00
12.00	CLINIC	90.00	0	282	0		12.00
13.00	EMERGENCY	91.00	0	185	0		13.00
14.00	HOME HEALTH AGENCY	101.00	0	1,191	0		14.00
	<b>TOTALS</b>		0	86,506			
500.00	<b>Grand Total: Decreases</b>		2,140,401	2,516,697			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0034

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
11/23/2021 10:33 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	13,037,475	0	0	0	0	1.00
2.00	Land Improvements	7,863,723	224,702	0	224,702	0	2.00
3.00	Buildings and Fixtures	129,138,378	255,383	0	255,383	180,000	3.00
4.00	Building Improvements	73,902,380	5,780,251	0	5,780,251	443,866	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	78,116,159	6,226,610	0	6,226,610	2,346,172	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	302,058,115	12,486,946	0	12,486,946	2,970,038	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	302,058,115	12,486,946	0	12,486,946	2,970,038	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	13,037,475	0				1.00
2.00	Land Improvements	8,088,425	0				2.00
3.00	Buildings and Fixtures	129,213,761	0				3.00
4.00	Building Improvements	79,238,765	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	81,996,597	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	311,575,023	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	311,575,023	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0034

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	8,197,404	1,350,724	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,671,240	2,585,967	0	0	0	2.00
3.00	Total (sum of lines 1-2)	13,868,644	3,936,691	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	9,548,128				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,257,207				2.00
3.00	Total (sum of lines 1-2)	0	17,805,335				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0034

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	229,578,426	0	229,578,426	0.736832	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	81,996,597	0	81,996,597	0.263168	0	2.00
3.00	Total (sum of lines 1-2)	311,575,023	0	311,575,023	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	7,668,476	1,350,724	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,788,702	2,585,967	2.00
3.00	Total (sum of lines 1-2)	0	0	0	14,457,178	3,936,691	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	182,087	0	0	9,201,287	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,193	0	0	9,387,862	2.00
3.00	Total (sum of lines 1-2)	0	195,280	0	0	18,589,149	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0034

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

Worksheet A-8

Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00		3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			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	9	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-235,210				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	-21,060,133				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	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

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	
33.00 ANESTHESIA - NON-SALARIES, NON-BENEF	A	-3,551,473	ANESTHESIOLOGY	53.00	0 33.00
33.01 COVID DRUG DONATIONS	B	-477,200	DRUGS CHARGED TO PATIENTS	73.00	0 33.01
33.07 NON-PATIENT CARE COST	A	-120	OTHER ADMINISTRATIVE & GENERAL	5.04	0 33.07
34.00 PART B CONTRACTED SERVICES	A	-2,149,412	NURSING ADMINISTRATION	13.00	0 34.00
34.01 PART B CONTRACTED SERVICES	A	-316,250	DELIVERY ROOM & LABOR ROOM	52.00	0 34.01
34.03 PART B CONTRACTED SERVICES	A	-5,520	RADIOLOGY-DIAGNOSTIC	54.00	0 34.03
34.04 PART B CONTRACTED SERVICES	A	-1,350	CT SCAN	57.00	0 34.04
35.00 PART B CONTRACTED SERVICES	A	-31,375	CARDIAC REHABILITATION	76.97	0 35.00
35.03 PART B SALARIES	A	-171,380	CLINIC	90.00	0 35.03
35.09 PRE-MERGER ASSETS DEPRECIATION	A	-413,206	CAP REL COSTS-BLDG & FIXT	1.00	9 35.09
35.10 PATIENT TELEPHONES	A	-139,823	OTHER ADMINISTRATIVE & GENERAL	5.04	0 35.10
35.12 TELEPHONE DEPRECIATION	A	-218	CAP REL COSTS-MVBLE EQUIP	2.00	9 35.12
37.00 TV DEPRECIATION	A	-2,000	CAP REL COSTS-MVBLE EQUIP	2.00	9 37.00
38.00 OTHER REVENUE	B	-248,239	CAP REL COSTS-BLDG & FIXT	1.00	9 38.00
39.00 OTHER REVENUE	B	-95	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 39.00
39.01 OTHER REVENUE	B	-6,942	OTHER ADMINISTRATIVE & GENERAL	5.04	0 39.01
39.02 OTHER REVENUE	B	-290	DIETARY	10.00	0 39.02
39.03 OTHER REVENUE	B	-1,870	NURSING ADMINISTRATION	13.00	0 39.03
39.04 OTHER REVENUE	B	-37,474	PARAMEDICAL EDUCATION PROGRAM EMS	23.00	0 39.04
39.05 OTHER REVENUE	B	-213	ADULTS & PEDIATRICS	30.00	0 39.05
39.06 OTHER REVENUE	B	-24	INTENSIVE CARE UNIT	31.00	0 39.06
41.03 OTHER REVENUE	B	-11	SUBPROVIDER - IRF	41.00	0 41.03
42.01 OTHER REVENUE	B	-2	RECOVERY ROOM	51.00	0 42.01
42.03 OTHER REVENUE	B	-18	DELIVERY ROOM & LABOR ROOM	52.00	0 42.03
42.05 OTHER REVENUE	B	-2,256	RADIOLOGY-DIAGNOSTIC	54.00	0 42.05
42.06 OTHER REVENUE	B	-2,243	CARDIAC CATHETERIZATION	59.00	0 42.06
43.00 OTHER REVENUE	B	-184,311	LABORATORY	60.00	0 43.00
43.03 OTHER REVENUE	B	-13,210	RESPIRATORY THERAPY	65.00	0 43.03
43.04 OTHER REVENUE	B	-2,311	CLINIC	90.00	0 43.04
43.05 OTHER REVENUE	B	-311	EMERGENCY	91.00	0 43.05
44.00 OTHER REVENUE	B	-485	HOME HEALTH AGENCY	101.00	0 44.00
46.00 OTHER REVENUE	B	-865,704	CAFETERIA	11.00	0 46.00
46.01 OTHER REVENUE	B	-8,605	CAP REL COSTS-MVBLE EQUIP	2.00	11 46.01
47.00 PART B BENEFITS	A	-17,005	CLINIC	90.00	0 47.00
47.01 PART B BENEFITS	A	-19,167	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 47.01
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-29,965,456			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: 15-0034

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

Worksheet A-8-1

Date/Time Prepared: 11/23/2021 10:33 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.04	OTHER ADMINISTRATIVE & GENERAL	OTHER NONCAPITAL COSTS	8,324,323	30,642,421 1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXTURE	BLDG DEPR	132,517	0 2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	EQ DEPR	1,119,680	0 3.00
3.01	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	2,535,834	0 3.01
3.02	5.03	CASHIERING/ACCOUNTS RECEIVABLE	PATIENT ACCTING	2,988,167	0 3.02
3.03	13.00	NURSING ADMINISTRATION	CANCER REGISTRY COSTS	153,568	0 3.03
3.04	4.00	EMPLOYEE BENEFITS DEPARTMENT	ALLOCATED FRINGE BENEFITS CO	1,524,424	0 3.04
3.05	5.04	OTHER ADMINISTRATIVE & GENERAL	ALLOCATED SALARY COSTS	7,392,542	0 3.05
4.00	5.04	OTHER ADMINISTRATIVE & GENERAL	PHYSICIAN ALLOCATION	0	14,588,767 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			24,171,055	45,231,188 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	CFNI	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:				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: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet A-8-1 Date/Time Prepared: 11/23/2021 10:33 am
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	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	-22,318,098	0		1.00
2.00	132,517	9		2.00
3.00	1,119,680	9		3.00
3.01	2,535,834	0		3.01
3.02	2,988,167	0		3.02
3.03	153,568	0		3.03
3.04	1,524,424	0		3.04
3.05	7,392,542	0		3.05
4.00	-14,588,767	0		4.00
5.00	-21,060,133			5.00

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

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

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the 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: 15-0034

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

Worksheet A-8-2

Date/Time Prepared:  
11/23/2021 10:33 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.04	AGGREGATE-OTHER ADMINISTRATIVE & GEN	357,411	0	357,411	211,500	2,340	1.00
2.00	13.00	AGGREGATE-NURSING ADMINISTRATION	18,225	0	18,225	211,500	122	2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	26,223	0	26,223	211,500	102	3.00
4.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	27,939	0	27,939	211,500	209	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	46,449	0	46,449	246,400	239	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	18,634	0	18,634	271,900	78	6.00
7.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	9,550	0	9,550	211,500	48	7.00
8.00	60.00	AGGREGATE-LABORATORY	66,600	0	66,600	260,300	333	8.00
9.00	65.00	AGGREGATE-RESPIRATORY THERAPY	3,132	0	3,132	211,500	29	9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	4,200	0	4,200	211,500	21	10.00
11.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	25,565	0	25,565	211,500	218	11.00
12.00	90.00	AGGREGATE-CLINIC	86,470	0	86,470	211,500	599	12.00
200.00			690,398	0	690,398		4,338	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.04	AGGREGATE-OTHER ADMINISTRATIVE & GEN	237,938	11,897	0	0	0	1.00
2.00	13.00	AGGREGATE-NURSING ADMINISTRATION	12,405	620	0	0	0	2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	10,372	519	0	0	0	3.00
4.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	21,252	1,063	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	28,312	1,416	0	0	0	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	10,196	510	0	0	0	6.00
7.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	4,881	244	0	0	0	7.00
8.00	60.00	AGGREGATE-LABORATORY	41,673	2,084	0	0	0	8.00
9.00	65.00	AGGREGATE-RESPIRATORY THERAPY	2,949	147	0	0	0	9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	2,135	107	0	0	0	10.00
11.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	22,167	1,108	0	0	0	11.00
12.00	90.00	AGGREGATE-CLINIC	60,908	3,045	0	0	0	12.00
200.00			455,188	22,760	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.04	AGGREGATE-OTHER ADMINISTRATIVE & GEN	0	237,938	119,473	119,473		1.00
2.00	13.00	AGGREGATE-NURSING ADMINISTRATION	0	12,405	5,820	5,820		2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	10,372	15,851	15,851		3.00
4.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	21,252	6,687	6,687		4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	28,312	18,137	18,137		5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	10,196	8,438	8,438		6.00
7.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	0	4,881	4,669	4,669		7.00
8.00	60.00	AGGREGATE-LABORATORY	0	41,673	24,927	24,927		8.00
9.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	2,949	183	183		9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	2,135	2,065	2,065		10.00
11.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	22,167	3,398	3,398		11.00
12.00	90.00	AGGREGATE-CLINIC	0	60,908	25,562	25,562		12.00
200.00			0	455,188	235,210	235,210		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0034

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

Worksheet B Part I Date/Time Prepared: 11/23/2021 10:33 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	PURCHASING RECEIVING AND STORES		
		BLDG & FIXT	MVBLE EQUIP				
		1.00	2.00				4.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 CAP REL COSTS-BLDG & FIXT	9,201,287	9,201,287				1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP	9,387,862		9,387,862			2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	14,023,354	40,455	1,706	14,065,515		4.00	
5.01 00560 PURCHASING RECEIVING AND STORES	475,923	73,030	9,829	70,137	628,919	5.01	
5.02 00570 ADMITTING	2,663,541	89,334	13,364	428,846	876	5.02	
5.03 00580 CASHIERING/ACCOUNTS RECEIVABLE	2,988,177	11,323	0	0	0	5.03	
5.04 00590 OTHER ADMINISTRATIVE & GENERAL	27,671,769	497,837	239,816	1,153,255	11,378	5.04	
7.00 00700 OPERATION OF PLANT	9,438,684	1,317,615	279,988	415,344	551	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	970,261	15,615	0	16,451	7	8.00	
9.00 00900 HOUSEKEEPING	2,755,770	63,117	5,865	369,253	2,241	9.00	
10.00 01000 DIETARY	2,144,453	115,679	60,124	233,645	2,799	10.00	
11.00 01100 CAFETERIA	310,987	77,562	0	128,187	0	11.00	
13.00 01300 NURSING ADMINISTRATION	4,434,520	68,418	6,378	651,212	4,491	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00	
15.00 01500 PHARMACY	0	0	0	0	0	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	2,535,834	33,840	0	0	0	16.00	
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00	
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00	
23.00 02300 PARAMEDICAL EDUCATION PROGRAM EMS	341,852	7,111	6,014	51,003	2,060	23.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	17,764,416	1,406,661	307,782	2,648,065	46,029	30.00	
31.00 03100 INTENSIVE CARE UNIT	4,991,191	210,426	321,246	706,724	19,520	31.00	
41.00 04100 SUBPROVIDER - IIRF	2,973,574	175,608	30,520	324,180	3,940	41.00	
43.00 04300 NURSERY	1,507,690	84,929	0	199,595	0	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	21,972,792	705,460	3,491,130	1,229,823	290,949	50.00	
51.00 05100 RECOVERY ROOM	3,488,145	246,973	137,504	523,934	9,082	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	923,140	70,163	289,131	164,080	7,318	52.00	
53.00 05300 ANESTHESIOLOGY	459,182	3,876	0	0	10,115	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	5,079,558	229,772	603,978	590,163	12,315	54.00	
55.00 05500 RADIOLOGY - THERAPEUTIC	1,210,987	48,334	170,645	98,326	531	55.00	
56.00 05600 RADIOISOTOPE	1,445,322	94,395	108,456	96,787	761	56.00	
57.00 05700 CT SCAN	2,057,535	52,242	108,409	187,203	6,584	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1,225,014	58,168	551,126	98,361	1,219	58.00	
59.00 05900 CARDIAC CATHETERIZATION	3,392,425	137,636	1,521,171	293,643	31,870	59.00	
60.00 06000 LABORATORY	11,081,232	180,990	125,344	682,662	102,158	60.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00	
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	1,341,790	14,286	29,124	28,704	4,897	63.00	
64.00 06400 INTRAVENOUS THERAPY	520,749	38,052	21,581	70,090	2,112	64.00	
65.00 06500 RESPIRATORY THERAPY	2,753,974	58,552	84,198	389,913	8,373	65.00	
66.00 06600 PHYSICAL THERAPY	3,299,410	278,955	40,739	1,496	1,958	66.00	
67.00 06700 OCCUPATIONAL THERAPY	1,000,372	16,400	1,477	183	105	67.00	
68.00 06800 SPEECH PATHOLOGY	486,323	4,484	740	0	92	68.00	
69.00 06900 ELECTROCARDIOLOGY	1,187,772	60,842	275,455	159,432	1,059	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	568,193	42,889	41,412	77,253	2,322	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8,952,312	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	12,453,228	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	16,936,884	56,198	256,602	438,158	3,631	73.00	
74.00 07400 RENAL DIALYSIS	834,241	0	0	0	1	74.00	
76.97 07697 CARDIAC REHABILITATION	559,129	125,512	3,771	89,142	253	76.97	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	1,922,683	182,239	55,978	211,112	4,418	90.00	
91.00 09100 EMERGENCY	5,989,420	298,991	120,733	786,564	32,826	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00 10100 HOME HEALTH AGENCY	2,970,492	0	2,878	450,507	59	101.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	230,693,449	7,293,969	9,324,214	14,063,433	628,900	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,403	0	0	0	190.00	
191.00 19100 RESEARCH	12,596	0	0	2,082	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	8,833	1,881,709	0	0	0	192.00	
194.00 07950 OTHER NON-REIMBURSABLE COST CENTER	718,324	0	62,927	0	16	194.00	
194.01 07952 ADVERTISING	216,251	14,206	721	0	3	194.01	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers		0	0	0	201.00	
202.00	TOTAL (sum lines 118 through 201)	231,649,453	9,201,287	9,387,862	14,065,515	628,919	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part I Date/Time Prepared: 11/23/2021 10:33 am
Cost Center Description	ADMINISTRATIVE	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT
	5.02	5.03	5A.03	5.04	7.00
<b>GENERAL SERVICE COST CENTERS</b>					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01 00560	PURCHASING RECEIVING AND STORES				5.01
5.02 00570	ADMINISTRATIVE	3,195,961			5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	2,999,500		5.03
5.04 00590	OTHER ADMINISTRATIVE & GENERAL	0	0	29,574,055	5.04
7.00 00700	OPERATION OF PLANT	0	0	29,574,055	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	1,676,050	13,128,232
9.00 00900	HOUSEKEEPING	0	0	146,694	28,584
10.00 01000	DIETARY	0	0	467,777	115,539
11.00 01100	CAFETERIA	0	0	374,178	211,757
13.00 01300	NURSING ADMINISTRATION	0	0	75,625	141,983
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	755,911	125,243
15.00 01500	PHARMACY	0	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0
17.00 01700	SOCIAL SERVICE	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0
23.00 02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	0	0	0
30.00 03000	ADULTS & PEDIATRICS	214,559	201,408	408,040	59,717
31.00 03100	INTENSIVE CARE UNIT	39,687	37,254		
41.00 04100	SUBPROVIDER - IRF	20,786	19,512		
43.00 04300	NURSERY	13,387	12,567		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
50.00 05000	OPERATING ROOM	427,901	401,099	28,519,154	4,173,750
51.00 05100	RECOVERY ROOM	54,441	51,105	4,511,184	660,221
52.00 05200	DELIVERY ROOM & LABOR ROOM	10,858	10,193	1,474,883	215,852
53.00 05300	ANESTHESIOLOGY	82,802	77,727	633,702	92,744
54.00 05400	RADIOLOGY-DIAGNOSTIC	167,745	157,464	6,840,995	1,001,193
55.00 05500	RADIOLOGY - THERAPEUTIC	51,571	48,410	1,628,804	238,379
56.00 05600	RADIOISOTOPE	51,800	48,625	1,846,146	270,187
57.00 05700	CT SCAN	228,090	214,110	2,854,173	417,714
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	98,157	92,141	2,124,186	310,879
59.00 05900	CARDIAC CATHETERIZATION	230,477	216,350	5,823,572	852,291
60.00 06000	LABORATORY	411,505	386,283	12,970,174	1,898,211
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0
63.00 06300	BLOOD STORAGE, PROCESSING, & TRANS.	16,618	15,599	1,451,018	212,359
64.00 06400	INTRAVENOUS THERAPY	10,703	10,047	673,334	98,544
65.00 06500	RESPIRATORY THERAPY	40,324	37,852	3,373,186	493,673
66.00 06600	PHYSICAL THERAPY	51,235	48,094	3,721,887	544,706
67.00 06700	OCCUPATIONAL THERAPY	18,834	17,679	1,055,050	154,409
68.00 06800	SPEECH PATHOLOGY	4,000	3,755	499,394	73,087
69.00 06900	ELECTROCARDIOLOGY	89,710	84,212	1,858,482	271,993
70.00 07000	ELECTROENCEPHALOGRAPHY	26,664	25,030	783,763	114,705
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	95,490	89,637	9,137,439	1,337,282
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	98,647	92,601	12,644,476	1,850,544
73.00 07300	DRUGS CHARGED TO PATIENTS	326,558	306,543	18,324,574	2,681,838
74.00 07400	RENAL DIALYSIS	10,771	10,111	855,124	125,149
76.97 07697	CARDIAC REHABILITATION	5,594	5,251	788,652	115,421
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000	CLINIC	18,444	17,314	2,412,188	353,029
91.00 09100	EMERGENCY	265,988	249,685	7,744,207	1,133,380
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART			0	
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00 10100	HOME HEALTH AGENCY	12,615	11,842	3,448,393	504,679
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	3,195,961	2,999,500	228,720,382	29,145,379
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	11,403	1,669
191.00 19100	RESEARCH	0	0	14,678	2,148
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,890,542	276,685
194.00 07950	OTHER NON-REIMBURSABLE COST CENTER	0	0	781,267	114,340
194.01 07952	ADVERTISING	0	0	231,181	33,834
200.00	Cross Foot Adjustments			0	
201.00	Negative Cost Centers	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	3,195,961	2,999,500	231,649,453	29,574,055

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part I Date/Time Prepared: 11/23/2021 10:33 am
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING RECEIVING AND STORES					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE & GENERAL					5.04
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,177,612				8.00
9.00	00900	HOUSEKEEPING	0	3,779,562			9.00
10.00	01000	DIETARY	0	61,641	3,204,276		10.00
11.00	01100	CAFETERIA	0	41,330	0	775,674	11.00
13.00	01300	NURSING ADMINISTRATION	0	36,457	0	40,817	6,123,447
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,032	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	3,789	0	3,578	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	883,821	749,555	2,409,458	198,046	2,584,165
31.00	03100	INTENSIVE CARE UNIT	125,669	112,128	159,804	42,687	557,086
41.00	04100	SUBPROVIDER - I RF	133,034	93,575	324,819	25,152	328,272
43.00	04300	NURSERY	35,088	45,256	0	12,738	166,264
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	375,912	0	88,654	1,157,008
51.00	05100	RECOVERY ROOM	0	131,602	129,450	32,081	418,642
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	37,387	76,656	10,471	136,675
53.00	05300	ANESTHESIOLOGY	0	2,065	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	122,437	0	42,209	0
55.00	05500	RADIOLOGY - THERAPEUTIC	0	25,755	0	5,773	0
56.00	05600	RADIOISOTOPE	0	50,299	0	4,870	0
57.00	05700	CT SCAN	0	27,838	0	12,178	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	30,995	0	6,306	0
59.00	05900	CARDIAC CATHETERIZATION	0	73,341	0	18,240	0
60.00	06000	LABORATORY	0	96,442	0	59,491	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	7,612	0	1,924	0
64.00	06400	INTRAVENOUS THERAPY	0	20,277	0	5,375	0
65.00	06500	RESPIRATORY THERAPY	0	31,200	0	26,407	0
66.00	06600	PHYSICAL THERAPY	0	148,644	0	54	0
67.00	06700	OCCUPATIONAL THERAPY	0	8,739	0	9	0
68.00	06800	SPEECH PATHOLOGY	0	2,390	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	32,421	0	10,471	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	22,854	0	6,071	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	29,946	0	24,068	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	66,881	0	5,746	75,021
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	97,108	0	13,777	0
91.00	09100	EMERGENCY	0	159,320	104,089	53,664	700,314
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	0	0	0	24,700	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,177,612	2,763,228	3,204,276	775,557	6,123,447
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,076	0	0	0
191.00	19100	RESEARCH	0	0	0	117	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,002,688	0	0	0
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER	0	0	0	0	0
194.01	07952	ADVERTISING	0	7,570	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	1,177,612	3,779,562	3,204,276	775,674	6,123,447

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0034		Period: From 07/01/2020 To 06/30/2021		Worksheet B Part I Date/Time Prepared: 11/23/2021 10:33 am	
Cost Center Description			CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			14.00	15.00	16.00	17.00	19.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE & GENERAL						5.04
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	0					14.00
15.00	01500	PHARMACY	0	0				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	3,025,730			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	0	203,130	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	37,573	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	19,679	0	0	41.00
43.00	04300	NURSERY	0	0	12,674	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	405,111	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51,542	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	10,280	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	78,391	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	158,810	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	48,824	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	49,040	0	0	56.00
57.00	05700	CT SCAN	0	0	215,940	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	92,929	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	218,200	0	0	59.00
60.00	06000	LABORATORY	0	0	389,586	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	15,733	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	10,133	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	38,176	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	48,506	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	17,831	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	3,787	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	84,932	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	25,244	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	90,404	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	93,392	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	309,164	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	10,198	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	5,296	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	17,462	0	0	90.00
91.00	09100	EMERGENCY	0	0	251,820	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	0	0	11,943	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	3,025,730	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07952	ADVERTISING	0	0	0	0	0	194.01
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)	0	0	3,025,730	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part I Date/Time Prepared: 11/23/2021 10:33 am
Cost Center Description			PARAMEDICAL EDUCATION PROGRAM EMS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
			23.00	24.00	25.00	26.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00560	PURCHASING RECEIVING AND STORES				5.01
5.02	00570	ADMITTING				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00590	OTHER ADMINISTRATIVE & GENERAL				5.04
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	488,141			23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	0	35,498,010	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,672,023	0	31.00
41.00	04100	SUBPROVIDER - IIRF	0	5,313,387	0	41.00
43.00	04300	NURSERY	0	2,511,750	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	36,327	36,047,305	0	50.00
51.00	05100	RECOVERY ROOM	0	6,386,821	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,090,642	0	52.00
53.00	05300	ANESTHESIOLOGY	0	813,997	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,586,257	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	2,036,014	0	55.00
56.00	05600	RADIOISOTOPE	0	2,393,337	0	56.00
57.00	05700	CT SCAN	0	3,623,475	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,671,775	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	7,237,595	0	59.00
60.00	06000	LABORATORY	0	15,745,217	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	1,714,797	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	877,320	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,069,825	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,974,442	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,266,059	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	586,867	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,369,675	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,031,148	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,565,125	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,588,412	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,472,464	0	73.00
74.00	07400	RENAL DIALYSIS	0	990,471	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	1,286,775	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	3,227,163	0	90.00
91.00	09100	EMERGENCY	437,057	11,131,172	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100	HOME HEALTH AGENCY	0	3,989,715	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	473,384	223,769,035	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	40,022	0	190.00
191.00	19100	RESEARCH	0	16,943	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,614,500	0	192.00
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER	12,487	908,094	0	194.00
194.01	07952	ADVERTISING	2,270	300,859	0	194.01
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	488,141	231,649,453	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0034

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

Worksheet B  
Part II  
Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	40,455	1,706	42,161	42,161 4.00
5.01 00560	PURCHASING RECEIVING AND STORES	0	73,030	9,829	82,859	210 5.01
5.02 00570	ADMINISTRATIVE	0	89,334	13,364	102,698	1,286 5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	11,323	0	11,323	0 5.03
5.04 00590	OTHER ADMINISTRATIVE & GENERAL	0	497,837	239,816	737,653	3,459 5.04
7.00 00700	OPERATION OF PLANT	0	1,317,615	279,988	1,597,603	1,246 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	15,615	0	15,615	49 8.00
9.00 00900	HOUSEKEEPING	0	63,117	5,865	68,982	1,107 9.00
10.00 01000	DIETARY	0	115,679	60,124	175,803	701 10.00
11.00 01100	CAFETERIA	0	77,562	0	77,562	384 11.00
13.00 01300	NURSING ADMINISTRATION	0	68,418	6,378	74,796	1,953 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00 01500	PHARMACY	0	0	0	0	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	33,840	0	33,840	0 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
23.00 02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	7,111	6,014	13,125	153 23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	1,406,661	307,782	1,714,443	7,922 30.00
31.00 03100	INTENSIVE CARE UNIT	0	210,426	321,246	531,672	2,120 31.00
41.00 04100	SUBPROVIDER - IIRF	0	175,608	30,520	206,128	972 41.00
43.00 04300	NURSERY	0	84,929	0	84,929	599 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	705,460	3,491,130	4,196,590	3,688 50.00
51.00 05100	RECOVERY ROOM	0	246,973	137,504	384,477	1,571 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	70,163	289,131	359,294	492 52.00
53.00 05300	ANESTHESIOLOGY	0	3,876	0	3,876	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	229,772	603,978	833,750	1,770 54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	0	48,334	170,645	218,979	295 55.00
56.00 05600	RADIOISOTOPE	0	94,395	108,456	202,851	290 56.00
57.00 05700	CT SCAN	0	52,242	108,409	160,651	561 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58,168	551,126	609,294	295 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	137,636	1,521,171	1,658,807	881 59.00
60.00 06000	LABORATORY	0	180,990	125,344	306,334	2,047 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0 62.00
63.00 06300	BLOOD STORING, PROCESSING, & TRANS.	0	14,286	29,124	43,410	86 63.00
64.00 06400	INTRAVENOUS THERAPY	0	38,052	21,581	59,633	210 64.00
65.00 06500	RESPIRATORY THERAPY	0	58,552	84,198	142,750	1,169 65.00
66.00 06600	PHYSICAL THERAPY	0	278,955	40,739	319,694	4 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	16,400	1,477	17,877	1 67.00
68.00 06800	SPEECH PATHOLOGY	0	4,484	740	5,224	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	60,842	275,455	336,297	478 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	42,889	41,412	84,301	232 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	56,198	256,602	312,800	1,314 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.97 07697	CARDIAC REHABILITATION	0	125,512	3,771	129,283	267 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	182,239	55,978	238,217	633 90.00
91.00 09100	EMERGENCY	0	298,991	120,733	419,724	2,359 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100	HOME HEALTH AGENCY	0	0	2,878	2,878	1,351 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	7,293,969	9,324,214	16,618,183	42,155 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,403	0	11,403	0 190.00
191.00 19100	RESEARCH	0	0	0	0	6 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	1,881,709	0	1,881,709	0 192.00
194.00 07950	OTHER NON-REIMBURSABLE COST CENTER	0	0	62,927	62,927	0 194.00
194.01 07952	ADVERTISING	0	14,206	721	14,927	0 194.01
200.00	Cross Foot Adjustments				0	0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	0	9,201,287	9,387,862	18,589,149	42,161 202.00



ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0034		Period: From 07/01/2020 To 06/30/2021		Worksheet B Part II Date/Time Prepared: 11/23/2021 10:33 am	
Cost Center Description			PURCHASING RECEIVING AND STORES	ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			5.01	5.02	5.03	5.04	7.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES	83,069					5.01
5.02	00570	ADMINITTING	116	104,100				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	11,323			5.03
5.04	00590	OTHER ADMINISTRATIVE & GENERAL	1,503	0	0	742,615		5.04
7.00	00700	OPERATION OF PLANT	73	0	0	42,087	1,641,009	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1	0	0	3,684	3,573	8.00
9.00	00900	HOUSEKEEPING	296	0	0	11,746	14,442	9.00
10.00	01000	DIETARY	370	0	0	9,396	26,469	10.00
11.00	01100	CAFETERIA	0	0	0	1,899	17,748	11.00
13.00	01300	NURSING ADMINISTRATION	593	0	0	18,981	15,655	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	9,444	7,743	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	272	0	0	1,500	1,627	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	6,080	6,967	783	83,014	321,869	30.00
31.00	03100	INTENSIVE CARE UNIT	2,578	1,289	145	23,248	48,149	31.00
41.00	04100	SUBPROVIDER - IRF	520	675	76	13,039	40,182	41.00
43.00	04300	NURSERY	0	435	49	6,682	19,433	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	38,427	14,214	1,225	104,795	161,422	50.00
51.00	05100	RECOVERY ROOM	1,200	1,768	199	16,579	56,512	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	967	353	40	5,420	16,055	52.00
53.00	05300	ANESTHESIOLOGY	1,336	2,689	302	2,329	887	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,627	5,447	612	25,141	52,576	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	70	1,675	188	5,986	11,060	55.00
56.00	05600	RADIOISOTOPE	101	1,682	189	6,785	21,599	56.00
57.00	05700	CT SCAN	870	7,406	832	10,489	11,954	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	161	3,187	358	7,806	13,310	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,209	7,484	841	21,402	31,494	59.00
60.00	06000	LABORATORY	13,493	13,362	1,501	47,665	41,414	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	647	540	61	5,332	3,269	63.00
64.00	06400	INTRAVENOUS THERAPY	279	348	39	2,475	8,707	64.00
65.00	06500	RESPIRATORY THERAPY	1,106	1,309	147	12,396	13,398	65.00
66.00	06600	PHYSICAL THERAPY	259	1,664	187	13,678	63,830	66.00
67.00	06700	OCCUPATIONAL THERAPY	14	612	69	3,877	3,753	67.00
68.00	06800	SPEECH PATHOLOGY	12	130	15	1,835	1,026	68.00
69.00	06900	ELECTROCARDIOLOGY	140	2,913	327	6,830	13,922	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	307	866	97	2,880	9,814	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,101	348	33,580	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,203	360	46,468	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	480	10,603	1,191	67,343	12,859	73.00
74.00	07400	RENAL DIALYSIS	0	350	39	3,143	0	74.00
76.97	07697	CARDIAC REHABILITATION	33	182	20	2,898	28,719	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	583	599	67	8,865	41,699	90.00
91.00	09100	EMERGENCY	4,336	8,637	970	28,460	68,414	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	8	410	46	12,673	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83,067	104,100	11,323	731,850	1,204,583	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	42	2,609	190.00
191.00	19100	RESEARCH	0	0	0	54	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	6,948	430,567	192.00
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER	2	0	0	2,871	0	194.00
194.01	07952	ADVERTISING	0	0	0	850	3,250	194.01
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)	83,069	104,100	11,323	742,615	1,641,009	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part II Date/Time Prepared: 11/23/2021 10:33 am
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION		
		8.00	9.00	10.00	11.00	13.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00560	PURCHASING RECEIVING AND STORES					5.01	
5.02	00570	ADMITTING					5.02	
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03	
5.04	00590	OTHER ADMINISTRATIVE & GENERAL					5.04	
7.00	00700	OPERATION OF PLANT					7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	22,922				8.00	
9.00	00900	HOUSEKEEPING	0	96,573			9.00	
10.00	01000	DIETARY	0	1,575	214,314		10.00	
11.00	01100	CAFETERIA	0	1,056	0	98,649	11.00	
13.00	01300	NURSING ADMINISTRATION	0	932	0	5,191	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00	
15.00	01500	PHARMACY	0	0	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	461	0	0	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	97	0	455	23.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	17,204	19,152	161,154	25,186	49,840	30.00
31.00	03100	INTENSIVE CARE UNIT	2,446	2,865	10,688	5,429	10,744	31.00
41.00	04100	SUBPROVIDER - I RF	2,589	2,391	21,725	3,199	6,331	41.00
43.00	04300	NURSERY	683	1,156	0	1,620	3,207	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	9,605	0	11,275	22,315	50.00
51.00	05100	RECOVERY ROOM	0	3,363	8,658	4,080	8,074	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	955	5,127	1,332	2,636	52.00
53.00	05300	ANESTHESIOLOGY	0	53	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,128	0	5,368	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	658	0	734	0	55.00
56.00	05600	RADIOISOTOPE	0	1,285	0	619	0	56.00
57.00	05700	CT SCAN	0	711	0	1,549	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	792	0	802	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,874	0	2,320	0	59.00
60.00	06000	LABORATORY	0	2,464	0	7,566	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	195	0	245	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	518	0	684	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	797	0	3,358	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,798	0	7	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	223	0	1	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	61	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	828	0	1,332	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	584	0	772	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	765	0	3,061	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	1,709	0	731	1,447	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	2,481	0	1,752	0	90.00
91.00	09100	EMERGENCY	0	4,071	6,962	6,825	13,507	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	0	0	0	3,141	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,922	70,603	214,314	98,634	118,101	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	155	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	15	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	25,622	0	0	0	192.00
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07952	ADVERTISING	0	193	0	0	0	194.01
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)	22,922	96,573	214,314	98,649	118,101	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0034		Period: From 07/01/2020 To 06/30/2021		Worksheet B Part II Date/Time Prepared: 11/23/2021 10:33 am	
Cost Center Description			CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			14.00	15.00	16.00	17.00	19.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE & GENERAL						5.04
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	0					14.00
15.00	01500	PHARMACY	0	0				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	51,488			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	0	3,444	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	637	0		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	334	0		41.00
43.00	04300	NURSERY	0	0	215	0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	7,052	0		50.00
51.00	05100	RECOVERY ROOM	0	0	874	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	174	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,329	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,693	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	828	0		55.00
56.00	05600	RADIOISOTOPE	0	0	832	0		56.00
57.00	05700	CT SCAN	0	0	3,661	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,576	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	3,700	0		59.00
60.00	06000	LABORATORY	0	0	6,606	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0		62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	267	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	172	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	647	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	822	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	302	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	64	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,440	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	428	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,533	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,584	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,242	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	173	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0	90	0		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	296	0		90.00
91.00	09100	EMERGENCY	0	0	4,270	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	0	0	203	0		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	51,488	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER	0	0	0	0		194.00
194.01	07952	ADVERTISING	0	0	0	0		194.01
200.00		Cross Foot Adjustments						0 200.00
201.00		Negative Cost Centers	0	0	0	0		0 201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	51,488	0	0	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part II Date/Time Prepared: 11/23/2021 10:33 am
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Cost Center Description		PARAMEDICAL EDUCATION PROGRAM EMS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00560	PURCHASING RECEIVING AND STORES				5.01
5.02	00570	ADMINISTRATIVE				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00590	OTHER ADMINISTRATIVE & GENERAL				5.04
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	17,229			23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS		2,417,058	0	30.00
31.00	03100	INTENSIVE CARE UNIT		642,010	0	31.00
41.00	04100	SUBPROVIDER - IRF		298,161	0	41.00
43.00	04300	NURSERY		119,008	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM		4,570,608	0	50.00
51.00	05100	RECOVERY ROOM		487,355	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		392,845	0	52.00
53.00	05300	ANESTHESIOLOGY		12,801	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		932,112	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC		240,473	0	55.00
56.00	05600	RADIOISOTOPE		236,233	0	56.00
57.00	05700	CT SCAN		198,684	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		637,581	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		1,733,012	0	59.00
60.00	06000	LABORATORY		442,452	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		54,052	0	63.00
64.00	06400	INTRAVENOUS THERAPY		73,065	0	64.00
65.00	06500	RESPIRATORY THERAPY		177,077	0	65.00
66.00	06600	PHYSICAL THERAPY		403,943	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		26,729	0	67.00
68.00	06800	SPEECH PATHOLOGY		8,367	0	68.00
69.00	06900	ELECTROCARDIOLOGY		364,507	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		100,281	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		38,562	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		51,615	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		415,658	0	73.00
74.00	07400	RENAL DIALYSIS		3,705	0	74.00
76.97	07697	CARDIAC REHABILITATION		165,379	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC		295,192	0	90.00
91.00	09100	EMERGENCY		568,535	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100	HOME HEALTH AGENCY		20,710	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	16,127,770	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		14,209	0	190.00
191.00	19100	RESEARCH		75	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		2,344,846	0	192.00
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER		65,800	0	194.00
194.01	07952	ADVERTISING		19,220	0	194.01
200.00		Cross Foot Adjustments	17,229	17,229	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,229	18,589,149	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0034

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

Worksheet B-1

Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING RECEIVING AND STORES (COSTED REQ)	ADMITTING (GROSS REVENUE)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	574,529				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		21,933,735			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,526	3,987	75,464,333		4.00
5.01 00560	PURCHASING RECEIVING AND STORES	4,560	22,965	376,299	856,466	5.01
5.02 00570	ADMITTING	5,578	31,224	2,300,847	1,193	1,165,984,894
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	707	0	0	0	0
5.04 00590	OTHER ADMINISTRATIVE & GENERAL	31,085	560,305	6,187,457	15,495	0
7.00 00700	OPERATION OF PLANT	82,272	654,162	2,228,409	751	0
8.00 00800	LAUNDRY & LINEN SERVICE	975	0	88,263	10	0
9.00 00900	HOUSEKEEPING	3,941	13,704	1,981,118	3,052	0
10.00 01000	DIETARY	7,223	140,473	1,253,553	3,812	0
11.00 01100	CAFETERIA	4,843	0	687,749	0	0
13.00 01300	NURSING ADMINISTRATION	4,272	14,901	3,493,889	6,116	0
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	0	0	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	2,113	0	0	0	0
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
23.00 02300	PARAMEDICAL EDUCATION PROGRAM EMS	444	14,051	273,643	2,806	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	87,832	719,099	14,207,317	62,683	78,277,528
31.00 03100	INTENSIVE CARE UNIT	13,139	750,558	3,791,721	26,582	14,478,897
41.00 04100	SUBPROVIDER - I RF	10,965	71,306	1,739,296	5,366	7,583,246
43.00 04300	NURSERY	5,303	0	1,070,870	0	4,884,078
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	44,049	8,156,646	6,598,256	396,214	156,113,456
51.00 05100	RECOVERY ROOM	15,421	321,264	2,811,016	12,368	19,861,864
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,381	675,525	880,325	9,966	3,961,432
53.00 05300	ANESTHESIOLOGY	242	0	0	13,774	30,208,580
54.00 05400	RADIOLOGY-DIAGNOSTIC	14,347	1,411,131	3,166,351	16,770	61,198,624
55.00 05500	RADIOLOGY - THERAPEUTIC	3,018	398,693	527,538	723	18,814,637
56.00 05600	RADIOISOTOPE	5,894	253,395	519,284	1,037	18,898,031
57.00 05700	CT SCAN	3,262	253,287	1,004,382	8,966	83,214,033
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	3,632	1,287,648	527,727	1,660	35,810,735
59.00 05900	CARDIAC CATHETERIZATION	8,594	3,554,054	1,575,454	43,401	84,084,840
60.00 06000	LABORATORY	11,301	292,854	3,662,627	139,120	150,129,358
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0
63.00 06300	BLOOD STORING, PROCESSING, & TRANS.	892	68,044	154,004	6,669	6,062,639
64.00 06400	INTRAVENOUS THERAPY	2,376	50,422	376,045	2,876	3,904,638
65.00 06500	RESPIRATORY THERAPY	3,656	196,719	2,091,965	11,402	14,711,344
66.00 06600	PHYSICAL THERAPY	17,418	95,183	8,025	2,667	18,691,954
67.00 06700	OCCUPATIONAL THERAPY	1,024	3,452	984	143	6,871,114
68.00 06800	SPEECH PATHOLOGY	280	1,728	0	125	1,459,228
69.00 06900	ELECTROCARDIOLOGY	3,799	643,572	855,385	1,442	32,729,078
70.00 07000	ELECTROENCEPHALOGRAPHY	2,678	96,754	414,480	3,162	9,727,891
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	34,837,691
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	35,989,313
73.00 07300	DRUGS CHARGED TO PATIENTS	3,509	599,524	2,350,808	4,945	119,138,311
74.00 07400	RENAL DIALYSIS	0	0	0	2	3,929,673
76.97 07697	CARDIAC REHABILITATION	7,837	8,810	478,263	344	2,040,795
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	11,379	130,787	1,132,662	6,016	6,729,049
91.00 09100	EMERGENCY	18,669	282,079	4,220,083	44,702	97,040,446
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100	HOME HEALTH AGENCY	0	6,723	2,417,067	80	4,602,391
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	455,436	21,785,029	75,453,162	856,440	1,165,984,894
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	712	0	0	0	0
191.00 19100	RESEARCH	0	0	11,171	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	117,494	0	0	0	0
194.00 07950	OTHER NON-REIMBURSABLE COST CENTER	0	147,022	0	22	0
194.01 07952	ADVERTISING	887	1,684	0	4	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	9,201,287	9,387,862	14,065,515	628,919	3,195,961

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0034

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

Worksheet B-1

Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING RECEIVING AND STORES (COSTED REQ)	ADMITTING (GROSS REVENUE)		
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					4.00
203.00	Unit cost multiplier (Wkst. B, Part I)	16.015357	0.428010	0.186386	0.734319	0.002741	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			42,161	83,069	104,100	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000559	0.096990	0.000089	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: 15-0034

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

Worksheet B-1

Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	
			5.03	5A.04	5.04	7.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00570	ADMINISTRATIVE						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,165,984,894					5.03
5.04	00590	OTHER ADMINISTRATIVE & GENERAL	0	-29,574,055	202,075,398			5.04
7.00	00700	OPERATION OF PLANT	0	0	11,452,182	447,801		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,002,334	975	48,128	8.00
9.00	00900	HOUSEKEEPING	0	0	3,196,246	3,941	0	9.00
10.00	01000	DIETARY	0	0	2,556,700	7,223	0	10.00
11.00	01100	CAFETERIA	0	0	516,736	4,843	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	5,165,019	4,272	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	2,569,674	2,113	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	0	408,040	444	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	78,277,528	0	22,588,920	87,832	36,121	30.00
31.00	03100	INTENSIVE CARE UNIT	14,478,897	0	6,326,048	13,139	5,136	31.00
41.00	04100	SUBPROVIDER - IIRF	7,583,246	0	3,548,120	10,965	5,437	41.00
43.00	04300	NURSERY	4,884,078	0	1,818,168	5,303	1,434	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	156,113,456	0	28,519,154	44,049	0	50.00
51.00	05100	RECOVERY ROOM	19,861,864	0	4,511,184	15,421	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,961,432	0	1,474,883	4,381	0	52.00
53.00	05300	ANESTHESIOLOGY	30,208,580	0	633,702	242	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	61,198,624	0	6,840,995	14,347	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	18,814,637	0	1,628,804	3,018	0	55.00
56.00	05600	RADIOISOTOPE	18,898,031	0	1,846,146	5,894	0	56.00
57.00	05700	CT SCAN	83,214,033	0	2,854,173	3,262	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	35,810,735	0	2,124,186	3,632	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	84,084,840	0	5,823,572	8,594	0	59.00
60.00	06000	LABORATORY	150,129,358	0	12,970,174	11,301	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	6,062,639	0	1,451,018	892	0	63.00
64.00	06400	INTRAVENOUS THERAPY	3,904,638	0	673,334	2,376	0	64.00
65.00	06500	RESPIRATORY THERAPY	14,711,344	0	3,373,186	3,656	0	65.00
66.00	06600	PHYSICAL THERAPY	18,691,954	0	3,721,887	17,418	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,871,114	0	1,055,050	1,024	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,459,228	0	499,394	280	0	68.00
69.00	06900	ELECTROCARDIOLOGY	32,729,078	0	1,858,482	3,799	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,727,891	0	783,763	2,678	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,837,691	0	9,137,439	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,989,313	0	12,644,476	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	119,138,311	0	18,324,574	3,509	0	73.00
74.00	07400	RENAL DIALYSIS	3,929,673	0	855,124	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	2,040,795	0	788,652	7,837	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	6,729,049	0	2,412,188	11,379	0	90.00
91.00	09100	EMERGENCY	97,040,446	0	7,744,207	18,669	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	4,602,391	0	3,448,393	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,165,984,894	-29,574,055	199,146,327	328,708	48,128	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	11,403	712	0	190.00
191.00	19100	RESEARCH	0	0	14,678	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,890,542	117,494	0	192.00
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER	0	0	781,267	0	0	194.00
194.01	07952	ADVERTISING	0	0	231,181	887	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,999,500		29,574,055	13,128,232	1,177,612	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.002573		0.146352	29.317112	24.468334	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0034

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

Worksheet B-1

Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description		CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	
		5.03	5A.04	5.04	7.00	8.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	11,323		742,615	1,641,009	22,922	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000010		0.003675	3.664594	0.476272	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: 15-0034

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

Worksheet B-1

Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description			HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTES)	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE & GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	442,885					9.00
10.00	01000	DIETARY	7,223	162,355				10.00
11.00	01100	CAFETERIA	4,843	0	85,858			11.00
13.00	01300	NURSING ADMINISTRATION	4,272	0	4,518	1,080,286		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,113	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	444	0	396	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	87,832	122,083	21,921	455,893	0	30.00
31.00	03100	INTENSIVE CARE UNIT	13,139	8,097	4,725	98,280	0	31.00
41.00	04100	SUBPROVIDER - IRF	10,965	16,458	2,784	57,913	0	41.00
43.00	04300	NURSERY	5,303	0	1,410	29,332	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	44,049	0	9,813	204,117	0	50.00
51.00	05100	RECOVERY ROOM	15,421	6,559	3,551	73,856	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,381	3,884	1,159	24,112	0	52.00
53.00	05300	ANESTHESIOLOGY	242	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,347	0	4,672	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,018	0	639	0	0	55.00
56.00	05600	RADIOISOTOPE	5,894	0	539	0	0	56.00
57.00	05700	CT SCAN	3,262	0	1,348	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,632	0	698	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	8,594	0	2,019	0	0	59.00
60.00	06000	LABORATORY	11,301	0	6,585	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	892	0	213	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	2,376	0	595	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,656	0	2,923	0	0	65.00
66.00	06600	PHYSICAL THERAPY	17,418	0	6	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,024	0	1	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	280	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,799	0	1,159	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,678	0	672	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	3,509	0	2,664	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	7,837	0	636	13,235	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	11,379	0	1,525	0	0	90.00
91.00	09100	EMERGENCY	18,669	5,274	5,940	123,548	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	0	0	2,734	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	323,792	162,355	85,845	1,080,286	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	712	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	13	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	117,494	0	0	0	0	192.00
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07952	ADVERTISING	887	0	0	0	0	194.01
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)	3,779,562	3,204,276	775,674	6,123,447	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.533958	19.736232	9.034382	5.668357	0.000000	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0034

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

Worksheet B-1

Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTES)	NURSING ADMINISTRATION (NURSING HO URS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	96,573	214,314	98,649	118,101	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.218054	1.320033	1.148979	0.109324	0.000000	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: 15-0034

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

Worksheet B-1

Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PARAMEDICAL EDUCATION PROGRAM EMS (ASSIGNED TIME)	
		15.00	16.00	17.00	19.00	23.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00560						5.01
5.02	00570						5.02
5.03	00580						5.03
5.04	00590						5.04
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						14.00
15.00	01500						15.00
16.00	01600	0	1,165,984,894				16.00
17.00	01700	0	0	0			17.00
19.00	01900	0	0	0	0		19.00
23.00	02300	0	0	0		860	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	78,277,528	0	0	0	30.00
31.00	03100	0	14,478,897	0	0	0	31.00
41.00	04100	0	7,583,246	0	0	0	41.00
43.00	04300	0	4,884,078	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	156,113,456	0	0	64	50.00
51.00	05100	0	19,861,864	0	0	0	51.00
52.00	05200	0	3,961,432	0	0	0	52.00
53.00	05300	0	30,208,580	0	0	0	53.00
54.00	05400	0	61,198,624	0	0	0	54.00
55.00	05500	0	18,814,637	0	0	0	55.00
56.00	05600	0	18,898,031	0	0	0	56.00
57.00	05700	0	83,214,033	0	0	0	57.00
58.00	05800	0	35,810,735	0	0	0	58.00
59.00	05900	0	84,084,840	0	0	0	59.00
60.00	06000	0	150,129,358	0	0	0	60.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	6,062,639	0	0	0	63.00
64.00	06400	0	3,904,638	0	0	0	64.00
65.00	06500	0	14,711,344	0	0	0	65.00
66.00	06600	0	18,691,954	0	0	0	66.00
67.00	06700	0	6,871,114	0	0	0	67.00
68.00	06800	0	1,459,228	0	0	0	68.00
69.00	06900	0	32,729,078	0	0	0	69.00
70.00	07000	0	9,727,891	0	0	0	70.00
71.00	07100	0	34,837,691	0	0	0	71.00
72.00	07200	0	35,989,313	0	0	0	72.00
73.00	07300	0	119,138,311	0	0	0	73.00
74.00	07400	0	3,929,673	0	0	0	74.00
76.97	07697	0	2,040,795	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	6,729,049	0	0	0	90.00
91.00	09100	0	97,040,446	0	0	770	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	0	4,602,391	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		0	1,165,984,894	0	0	834	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
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
194.00	07950	0	0	0	0	22	194.00
194.01	07952	0	0	0	0	4	194.01
200.00							200.00
201.00							201.00
202.00		0	3,025,730	0	0	488,141	202.00
203.00		0.000000	0.002595	0.000000	0.000000	567.605814	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0034

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

Worksheet B-1

Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PARAMEDICAL EDUCATION PROGRAM EMS (ASSIGNED TIME)	
		15.00	16.00	17.00	19.00	23.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	0	51,488	0	0	17,229	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000044	0.000000	0.000000	20.033721	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/23/2021 10:33 am	
			Title XVIII	Hospital	PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		35,498,010	15,851	35,513,861	30.00
31.00	03100 INTENSIVE CARE UNIT		8,672,023	6,687	8,678,710	31.00
41.00	04100 SUBPROVIDER - I RF		5,313,387	0	5,313,387	41.00
43.00	04300 NURSERY		2,511,750	0	2,511,750	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		36,047,305	18,137	36,065,442	50.00
51.00	05100 RECOVERY ROOM		6,386,821	0	6,386,821	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		2,090,642	0	2,090,642	52.00
53.00	05300 ANESTHESIOLOGY		813,997	0	813,997	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		8,586,257	8,438	8,594,695	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC		2,036,014	0	2,036,014	55.00
56.00	05600 RADIOISOTOPE		2,393,337	0	2,393,337	56.00
57.00	05700 CT SCAN		3,623,475	0	3,623,475	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		2,671,775	0	2,671,775	58.00
59.00	05900 CARDIAC CATHETERIZATION		7,237,595	4,669	7,242,264	59.00
60.00	06000 LABORATORY		15,745,217	24,927	15,770,144	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.		1,714,797	0	1,714,797	63.00
64.00	06400 INTRAVENOUS THERAPY		877,320	0	877,320	64.00
65.00	06500 RESPIRATORY THERAPY	0	4,069,825	183	4,070,008	65.00
66.00	06600 PHYSICAL THERAPY	0	4,974,442	0	4,974,442	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,266,059	0	1,266,059	67.00
68.00	06800 SPEECH PATHOLOGY	0	586,867	0	586,867	68.00
69.00	06900 ELECTROCARDIOLOGY		2,369,675	2,065	2,371,740	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		1,031,148	3,398	1,034,546	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		10,565,125	0	10,565,125	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		14,588,412	0	14,588,412	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		21,472,464	0	21,472,464	73.00
74.00	07400 RENAL DIALYSIS		990,471	0	990,471	74.00
76.97	07697 CARDIAC REHABILITATION		1,286,775	0	1,286,775	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC		3,227,163	25,562	3,252,725	90.00
91.00	09100 EMERGENCY		11,131,172	0	11,131,172	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		4,390,866	0	4,390,866	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100 HOME HEALTH AGENCY		3,989,715		3,989,715	101.00
200.00	Subtotal (see instructions)	0	228,159,901	109,917	228,269,818	200.00
201.00	Less Observation Beds		4,390,866		4,390,866	201.00
202.00	Total (see instructions)	0	223,769,035	109,917	223,878,952	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0034		Period: From 07/01/2020 To 06/30/2021		Worksheet C Part I Date/Time Prepared: 11/23/2021 10:33 am		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	63,462,005		63,462,005				30.00
31.00	03100	INTENSIVE CARE UNIT	14,478,897		14,478,897				31.00
41.00	04100	SUBPROVIDER - IRF	7,583,246		7,583,246				41.00
43.00	04300	NURSERY	4,884,078		4,884,078				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	46,183,088	109,930,368	156,113,456	0.230905	0.000000		50.00
51.00	05100	RECOVERY ROOM	4,851,380	15,010,484	19,861,864	0.321562	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,892,616	1,068,816	3,961,432	0.527749	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	8,313,031	21,895,549	30,208,580	0.026946	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,563,149	52,635,475	61,198,624	0.140301	0.000000		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	543,865	18,270,772	18,814,637	0.108214	0.000000		55.00
56.00	05600	RADIOISOTOPE	2,596,867	16,301,164	18,898,031	0.126645	0.000000		56.00
57.00	05700	CT SCAN	22,298,071	60,915,962	83,214,033	0.043544	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,091,707	29,719,028	35,810,735	0.074608	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	22,905,292	61,179,548	84,084,840	0.086075	0.000000		59.00
60.00	06000	LABORATORY	43,292,107	106,837,251	150,129,358	0.104878	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0.000000	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	3,728,693	2,333,946	6,062,639	0.282847	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	24,549	3,880,089	3,904,638	0.224687	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	13,047,811	1,663,533	14,711,344	0.276645	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	5,482,840	13,209,114	18,691,954	0.266127	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,397,789	2,473,325	6,871,114	0.184258	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	895,092	564,136	1,459,228	0.402176	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	7,651,969	25,077,109	32,729,078	0.072403	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	432,431	9,295,460	9,727,891	0.105999	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,754,427	17,083,264	34,837,691	0.303267	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,000,482	17,988,831	35,989,313	0.405354	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,403,214	57,735,097	119,138,311	0.180231	0.000000		73.00
74.00	07400	RENAL DIALYSIS	3,735,249	194,424	3,929,673	0.252049	0.000000		74.00
76.97	07697	CARDIAC REHABILITATION	299,083	1,741,712	2,040,795	0.630526	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	286,726	6,442,323	6,729,049	0.479587	0.000000		90.00
91.00	09100	EMERGENCY	31,049,326	65,991,120	97,040,446	0.114707	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,192,843	12,622,680	14,815,523	0.296369	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0	4,602,391	4,602,391				101.00
200.00		Subtotal (see instructions)	429,321,923	736,662,971	1,165,984,894				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	429,321,923	736,662,971	1,165,984,894				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/23/2021 10:33 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.231021		50.00
51.00	05100 RECOVERY ROOM	0.321562		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.527749		52.00
53.00	05300 ANESTHESIOLOGY	0.026946		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.140439		54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.108214		55.00
56.00	05600 RADIOISOTOPE	0.126645		56.00
57.00	05700 CT SCAN	0.043544		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.074608		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.086130		59.00
60.00	06000 LABORATORY	0.105044		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.282847		63.00
64.00	06400 INTRAVENOUS THERAPY	0.224687		64.00
65.00	06500 RESPIRATORY THERAPY	0.276658		65.00
66.00	06600 PHYSICAL THERAPY	0.266127		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.184258		67.00
68.00	06800 SPEECH PATHOLOGY	0.402176		68.00
69.00	06900 ELECTROCARDIOLOGY	0.072466		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.106348		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.303267		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.405354		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.180231		73.00
74.00	07400 RENAL DIALYSIS	0.252049		74.00
76.97	07697 CARDIAC REHABILITATION	0.630526		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.483386		90.00
91.00	09100 EMERGENCY	0.114707		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.296369		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
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: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/23/2021 10:33 am	
			Title XIX	Hospital	PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		35,498,010	15,851	35,513,861	30.00
31.00	03100 INTENSIVE CARE UNIT		8,672,023	6,687	8,678,710	31.00
41.00	04100 SUBPROVIDER - I RF		5,313,387	0	5,313,387	41.00
43.00	04300 NURSERY		2,511,750	0	2,511,750	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		36,047,305	18,137	36,065,442	50.00
51.00	05100 RECOVERY ROOM		6,386,821	0	6,386,821	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		2,090,642	0	2,090,642	52.00
53.00	05300 ANESTHESIOLOGY		813,997	0	813,997	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		8,586,257	8,438	8,594,695	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC		2,036,014	0	2,036,014	55.00
56.00	05600 RADIOISOTOPE		2,393,337	0	2,393,337	56.00
57.00	05700 CT SCAN		3,623,475	0	3,623,475	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		2,671,775	0	2,671,775	58.00
59.00	05900 CARDIAC CATHETERIZATION		7,237,595	4,669	7,242,264	59.00
60.00	06000 LABORATORY		15,745,217	24,927	15,770,144	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.		1,714,797	0	1,714,797	63.00
64.00	06400 INTRAVENOUS THERAPY		877,320	0	877,320	64.00
65.00	06500 RESPIRATORY THERAPY	0	4,069,825	183	4,070,008	65.00
66.00	06600 PHYSICAL THERAPY	0	4,974,442	0	4,974,442	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,266,059	0	1,266,059	67.00
68.00	06800 SPEECH PATHOLOGY	0	586,867	0	586,867	68.00
69.00	06900 ELECTROCARDIOLOGY		2,369,675	2,065	2,371,740	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		1,031,148	3,398	1,034,546	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		10,565,125	0	10,565,125	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		14,588,412	0	14,588,412	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		21,472,464	0	21,472,464	73.00
74.00	07400 RENAL DIALYSIS		990,471	0	990,471	74.00
76.97	07697 CARDIAC REHABILITATION		1,286,775	0	1,286,775	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC		3,227,163	25,562	3,252,725	90.00
91.00	09100 EMERGENCY		11,131,172	0	11,131,172	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		4,390,866	0	4,390,866	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100 HOME HEALTH AGENCY		3,989,715		3,989,715	101.00
200.00	Subtotal (see instructions)	0	228,159,901	109,917	228,269,818	200.00
201.00	Less Observation Beds		4,390,866		4,390,866	201.00
202.00	Total (see instructions)	0	223,769,035	109,917	223,878,952	202.00



COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0034		Period: From 07/01/2020 To 06/30/2021		Worksheet C Part I Date/Time Prepared: 11/23/2021 10:33 am	
			Title XIX		Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	63,462,005		63,462,005			30.00
31.00	03100	INTENSIVE CARE UNIT	14,478,897		14,478,897			31.00
41.00	04100	SUBPROVIDER - IRF	7,583,246		7,583,246			41.00
43.00	04300	NURSERY	4,884,078		4,884,078			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	46,183,088	109,930,368	156,113,456	0.230905	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,851,380	15,010,484	19,861,864	0.321562	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,892,616	1,068,816	3,961,432	0.527749	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,313,031	21,895,549	30,208,580	0.026946	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,563,149	52,635,475	61,198,624	0.140301	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	543,865	18,270,772	18,814,637	0.108214	0.000000	55.00
56.00	05600	RADIOISOTOPE	2,596,867	16,301,164	18,898,031	0.126645	0.000000	56.00
57.00	05700	CT SCAN	22,298,071	60,915,962	83,214,033	0.043544	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,091,707	29,719,028	35,810,735	0.074608	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	22,905,292	61,179,548	84,084,840	0.086075	0.000000	59.00
60.00	06000	LABORATORY	43,292,107	106,837,251	150,129,358	0.104878	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0.000000	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	3,728,693	2,333,946	6,062,639	0.282847	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	24,549	3,880,089	3,904,638	0.224687	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	13,047,811	1,663,533	14,711,344	0.276645	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,482,840	13,209,114	18,691,954	0.266127	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,397,789	2,473,325	6,871,114	0.184258	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	895,092	564,136	1,459,228	0.402176	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	7,651,969	25,077,109	32,729,078	0.072403	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	432,431	9,295,460	9,727,891	0.105999	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,754,427	17,083,264	34,837,691	0.303267	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,000,482	17,988,831	35,989,313	0.405354	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,403,214	57,735,097	119,138,311	0.180231	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,735,249	194,424	3,929,673	0.252049	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	299,083	1,741,712	2,040,795	0.630526	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	286,726	6,442,323	6,729,049	0.479587	0.000000	90.00
91.00	09100	EMERGENCY	31,049,326	65,991,120	97,040,446	0.114707	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,192,843	12,622,680	14,815,523	0.296369	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	0	4,602,391	4,602,391			101.00
200.00		Subtotal (see instructions)	429,321,923	736,662,971	1,165,984,894			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	429,321,923	736,662,971	1,165,984,894			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/23/2021 10:33 am
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.231021		50.00
51.00	05100 RECOVERY ROOM	0.321562		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.527749		52.00
53.00	05300 ANESTHESIOLOGY	0.026946		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.140439		54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.108214		55.00
56.00	05600 RADIOISOTOPE	0.126645		56.00
57.00	05700 CT SCAN	0.043544		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.074608		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.086130		59.00
60.00	06000 LABORATORY	0.105044		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.282847		63.00
64.00	06400 INTRAVENOUS THERAPY	0.224687		64.00
65.00	06500 RESPIRATORY THERAPY	0.276658		65.00
66.00	06600 PHYSICAL THERAPY	0.266127		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.184258		67.00
68.00	06800 SPEECH PATHOLOGY	0.402176		68.00
69.00	06900 ELECTROCARDIOLOGY	0.072466		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.106348		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.303267		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.405354		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.180231		73.00
74.00	07400 RENAL DIALYSIS	0.252049		74.00
76.97	07697 CARDIAC REHABILITATION	0.630526		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.483386		90.00
91.00	09100 EMERGENCY	0.114707		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.296369		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
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

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

Provider CCN: 15-0034

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

Worksheet C Part II Date/Time Prepared: 11/23/2021 10:33 am

Cost Center Description			Title XIX			Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	36,047,305	4,570,608	31,476,697	0	0	50.00
51.00	05100	RECOVERY ROOM	6,386,821	487,355	5,899,466	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,090,642	392,845	1,697,797	0	0	52.00
53.00	05300	ANESTHESIOLOGY	813,997	12,801	801,196	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,586,257	932,112	7,654,145	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	2,036,014	240,473	1,795,541	0	0	55.00
56.00	05600	RADIOISOTOPE	2,393,337	236,233	2,157,104	0	0	56.00
57.00	05700	CT SCAN	3,623,475	198,684	3,424,791	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,671,775	637,581	2,034,194	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,237,595	1,733,012	5,504,583	0	0	59.00
60.00	06000	LABORATORY	15,745,217	442,452	15,302,765	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	1,714,797	54,052	1,660,745	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	877,320	73,065	804,255	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,069,825	177,077	3,892,748	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,974,442	403,943	4,570,499	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,266,059	26,729	1,239,330	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	586,867	8,367	578,500	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,369,675	364,507	2,005,168	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,031,148	100,281	930,867	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,565,125	38,562	10,526,563	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,588,412	51,615	14,536,797	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,472,464	415,658	21,056,806	0	0	73.00
74.00	07400	RENAL DIALYSIS	990,471	3,705	986,766	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	1,286,775	165,379	1,121,396	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	3,227,163	295,192	2,931,971	0	0	90.00
91.00	09100	EMERGENCY	11,131,172	568,535	10,562,637	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,390,866	298,842	4,092,024	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	3,989,715	20,710	3,969,005	0	0	101.00
200.00		Subtotal (sum of lines 50 thru 199)	176,164,731	12,950,375	163,214,356	0	0	200.00
201.00		Less Observation Beds	4,390,866	298,842	4,092,024	0	0	201.00
202.00		Total (line 200 minus line 201)	171,773,865	12,651,533	159,122,332	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part II Date/Time Prepared: 11/23/2021 10:33 am
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Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	36,047,305	156,113,456	0.230905		50.00
51.00	05100 RECOVERY ROOM	6,386,821	19,861,864	0.321562		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,090,642	3,961,432	0.527749		52.00
53.00	05300 ANESTHESIOLOGY	813,997	30,208,580	0.026946		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,586,257	61,198,624	0.140301		54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	2,036,014	18,814,637	0.108214		55.00
56.00	05600 RADIOISOTOPE	2,393,337	18,898,031	0.126645		56.00
57.00	05700 CT SCAN	3,623,475	83,214,033	0.043544		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2,671,775	35,810,735	0.074608		58.00
59.00	05900 CARDIAC CATHETERIZATION	7,237,595	84,084,840	0.086075		59.00
60.00	06000 LABORATORY	15,745,217	150,129,358	0.104878		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.000000		62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	1,714,797	6,062,639	0.282847		63.00
64.00	06400 INTRAVENOUS THERAPY	877,320	3,904,638	0.224687		64.00
65.00	06500 RESPIRATORY THERAPY	4,069,825	14,711,344	0.276645		65.00
66.00	06600 PHYSICAL THERAPY	4,974,442	18,691,954	0.266127		66.00
67.00	06700 OCCUPATIONAL THERAPY	1,266,059	6,871,114	0.184258		67.00
68.00	06800 SPEECH PATHOLOGY	586,867	1,459,228	0.402176		68.00
69.00	06900 ELECTROCARDIOLOGY	2,369,675	32,729,078	0.072403		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,031,148	9,727,891	0.105999		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10,565,125	34,837,691	0.303267		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	14,588,412	35,989,313	0.405354		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	21,472,464	119,138,311	0.180231		73.00
74.00	07400 RENAL DIALYSIS	990,471	3,929,673	0.252049		74.00
76.97	07697 CARDIAC REHABILITATION	1,286,775	2,040,795	0.630526		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	3,227,163	6,729,049	0.479587		90.00
91.00	09100 EMERGENCY	11,131,172	97,040,446	0.114707		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4,390,866	14,815,523	0.296369		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100 HOME HEALTH AGENCY	3,989,715	4,602,391	0.866879		101.00
200.00	Subtotal (sum of lines 50 thru 199)	176,164,731	1,075,576,668			200.00
201.00	Less Observation Beds	4,390,866	0			201.00
202.00	Total (line 200 minus line 201)	171,773,865	1,075,576,668			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part I Date/Time Prepared: 11/23/2021 10:33 am
Title XVIII			Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,417,058	0	2,417,058	41,217	58.64	30.00
31.00	INTENSIVE CARE UNIT	642,010		642,010	5,136	125.00	31.00
41.00	SUBPROVIDER - IRF	298,161	0	298,161	5,437	54.84	41.00
43.00	NURSERY	119,008		119,008	1,434	82.99	43.00
200.00	Total (lines 30 through 199)	3,476,237		3,476,237	53,224		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	15,204	891,563				
31.00	INTENSIVE CARE UNIT	1,795	224,375				
41.00	SUBPROVIDER - IRF	3,441	188,704				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	20,440	1,304,642				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0034

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

Worksheet D  
Part II  
Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,570,608	156,113,456	0.029277	16,722,426	489,582	50.00
51.00	05100	RECOVERY ROOM	487,355	19,861,864	0.024537	1,847,635	45,335	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	392,845	3,961,432	0.099167	0	0	52.00
53.00	05300	ANESTHESIOLOGY	12,801	30,208,580	0.000424	3,185,479	1,351	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	932,112	61,198,624	0.015231	3,499,931	53,307	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	240,473	18,814,637	0.012781	88,266	1,128	55.00
56.00	05600	RADIOISOTOPE	236,233	18,898,031	0.012500	1,137,421	14,218	56.00
57.00	05700	CT SCAN	198,684	83,214,033	0.002388	9,127,027	21,795	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	637,581	35,810,735	0.017804	2,210,399	39,354	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,733,012	84,084,840	0.020610	9,892,473	203,884	59.00
60.00	06000	LABORATORY	442,452	150,129,358	0.002947	16,923,053	49,872	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.000000	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	54,052	6,062,639	0.008916	1,328,948	11,849	63.00
64.00	06400	INTRAVENOUS THERAPY	73,065	3,904,638	0.018712	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	177,077	14,711,344	0.012037	5,166,665	62,191	65.00
66.00	06600	PHYSICAL THERAPY	403,943	18,691,954	0.021611	1,352,055	29,219	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,729	6,871,114	0.003890	868,691	3,379	67.00
68.00	06800	SPEECH PATHOLOGY	8,367	1,459,228	0.005734	205,286	1,177	68.00
69.00	06900	ELECTROCARDIOLOGY	364,507	32,729,078	0.011137	3,342,772	37,228	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	100,281	9,727,891	0.010309	175,478	1,809	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	38,562	34,837,691	0.001107	6,825,062	7,555	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,615	35,989,313	0.001434	8,786,918	12,600	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	415,658	119,138,311	0.003489	22,482,092	78,440	73.00
74.00	07400	RENAL DIALYSIS	3,705	3,929,673	0.000943	1,590,857	1,500	74.00
76.97	07697	CARDIAC REHABILITATION	165,379	2,040,795	0.081037	112,898	9,149	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	295,192	6,729,049	0.043868	83,686	3,671	90.00
91.00	09100	EMERGENCY	568,535	97,040,446	0.005859	13,127,160	76,912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	298,842	14,815,523	0.020171	1,105,047	22,290	92.00
200.00		Total (lines 50 through 199)	12,929,665	1,070,974,277		131,187,725	1,278,795	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part III Date/Time Prepared: 11/23/2021 10:33 am
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	41,217	0.00	15,204	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	5,136	0.00	1,795	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	5,437	0.00	3,441	41.00	
43.00	04300	NURSERY	0	0	1,434	0.00	0	43.00	
200.00		Total (lines 30 through 199)	0	0	53,224		20,440	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Prepared: 11/23/2021 10:33 am
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Cost Center Description	Title XVIII				Hospital		Allied Health	Allied Health	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	PPS				
	1.00	2A	2.00	3A	3.00				
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	0	0	0	0	36,327	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	437,057	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	473,384	0	200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Title XVIII		Hospital		
					Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)			
		4.00	5.00	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	36,327	36,327	156,113,456	0.000233	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	19,861,864	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,961,432	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	30,208,580	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	61,198,624	0.000000	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	18,814,637	0.000000	55.00	
56.00	05600	RADIOISOTOPE	0	0	0	18,898,031	0.000000	56.00	
57.00	05700	CT SCAN	0	0	0	83,214,033	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	35,810,735	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	84,084,840	0.000000	59.00	
60.00	06000	LABORATORY	0	0	0	150,129,358	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0.000000	62.00	
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	6,062,639	0.000000	63.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,904,638	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,711,344	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	18,691,954	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,871,114	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,459,228	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	32,729,078	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	9,727,891	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	34,837,691	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,989,313	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	119,138,311	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	3,929,673	0.000000	74.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,040,795	0.000000	76.97	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	6,729,049	0.000000	90.00	
91.00	09100	EMERGENCY	0	437,057	437,057	97,040,446	0.004504	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	14,815,523	0.000000	92.00	
200.00		Total (lines 50 through 199)	0	473,384	473,384	1,070,974,277		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000233	16,722,426	3,896	28,537,580	6,649	50.00
51.00	05100 RECOVERY ROOM	0.000000	1,847,635	0	3,921,700	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	3,185,479	0	5,488,682	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	3,499,931	0	12,722,958	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000	88,266	0	7,269,147	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	1,137,421	0	5,386,740	0	56.00
57.00	05700 CT SCAN	0.000000	9,127,027	0	15,760,538	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	2,210,399	0	6,843,077	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	9,892,473	0	23,656,069	0	59.00
60.00	06000 LABORATORY	0.000000	16,923,053	0	10,133,082	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000	1,328,948	0	697,570	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	1,608,482	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	5,166,665	0	415,927	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,352,055	0	22,434	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	868,691	0	2,038	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	205,286	0	4,045	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	3,342,772	0	8,140,588	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	175,478	0	2,104,067	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	6,825,062	0	5,441,772	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	8,786,918	0	5,381,232	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	22,482,092	0	22,781,062	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	1,590,857	0	88,311	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	112,898	0	712,490	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	83,686	0	2,566,833	0	90.00
91.00	09100 EMERGENCY	0.004504	13,127,160	59,125	11,243,346	50,640	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,105,047	0	2,695,434	0	92.00
200.00	Total (lines 50 through 199)		131,187,725	63,021	183,625,204	57,289	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Prepared: 11/23/2021 10:33 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.230905	28,537,580	0	37,180	6,589,470	50.00
51.00	05100 RECOVERY ROOM	0.321562	3,921,700	0	0	1,261,070	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.527749	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.026946	5,488,682	0	0	147,898	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.140301	12,722,958	0	0	1,785,044	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.108214	7,269,147	0	0	786,623	55.00
56.00	05600 RADIOISOTOPE	0.126645	5,386,740	0	0	682,204	56.00
57.00	05700 CT SCAN	0.043544	15,760,538	0	0	686,277	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.074608	6,843,077	0	0	510,548	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.086075	23,656,069	0	0	2,036,196	59.00
60.00	06000 LABORATORY	0.104878	10,133,082	0	0	1,062,737	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.282847	697,570	0	0	197,306	63.00
64.00	06400 INTRAVENOUS THERAPY	0.224687	1,608,482	0	0	361,405	64.00
65.00	06500 RESPIRATORY THERAPY	0.276645	415,927	0	0	115,064	65.00
66.00	06600 PHYSICAL THERAPY	0.266127	22,434	0	0	5,970	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.184258	2,038	0	0	376	67.00
68.00	06800 SPEECH PATHOLOGY	0.402176	4,045	0	0	1,627	68.00
69.00	06900 ELECTROCARDIOLOGY	0.072403	8,140,588	0	0	589,403	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.105999	2,104,067	0	0	223,029	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.303267	5,441,772	0	400	1,650,310	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.405354	5,381,232	0	0	2,181,304	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.180231	22,781,062	0	79,410	4,105,854	73.00
74.00	07400 RENAL DIALYSIS	0.252049	88,311	0	0	22,259	74.00
76.97	07697 CARDIAC REHABILITATION	0.630526	712,490	0	0	449,243	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.479587	2,566,833	0	0	1,231,020	90.00
91.00	09100 EMERGENCY	0.114707	11,243,346	0	0	1,289,690	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.296369	2,695,434	0	0	798,843	92.00
200.00	Subtotal (see instructions)		183,625,204	0	116,990	28,770,770	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		183,625,204	0	116,990	28,770,770	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Prepared: 11/23/2021 10:33 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	8,585	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	121	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	14,312	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Subtotal (see instructions)	0	23,018	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	23,018	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 15-0034 Component CCN: 15-T034		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part II Date/Time Prepared: 11/23/2021 10:33 am	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,570,608	156,113,456	0.029277	69,928	2,047	50.00
51.00	05100	RECOVERY ROOM	487,355	19,861,864	0.024537	5,684	139	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	392,845	3,961,432	0.099167	0	0	52.00
53.00	05300	ANESTHESIOLOGY	12,801	30,208,580	0.000424	7,069	3	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	932,112	61,198,624	0.015231	147,109	2,241	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	240,473	18,814,637	0.012781	56,059	716	55.00
56.00	05600	RADIOISOTOPE	236,233	18,898,031	0.012500	11,663	146	56.00
57.00	05700	CT SCAN	198,684	83,214,033	0.002388	193,462	462	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	637,581	35,810,735	0.017804	46,362	825	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,733,012	84,084,840	0.020610	23,053	475	59.00
60.00	06000	LABORATORY	442,452	150,129,358	0.002947	685,816	2,021	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.000000	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	54,052	6,062,639	0.008916	18,365	164	63.00
64.00	06400	INTRAVENOUS THERAPY	73,065	3,904,638	0.018712	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	177,077	14,711,344	0.012037	412,869	4,970	65.00
66.00	06600	PHYSICAL THERAPY	403,943	18,691,954	0.021611	1,658,733	35,847	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,729	6,871,114	0.003890	1,637,071	6,368	67.00
68.00	06800	SPEECH PATHOLOGY	8,367	1,459,228	0.005734	233,688	1,340	68.00
69.00	06900	ELECTROCARDIOLOGY	364,507	32,729,078	0.011137	57,585	641	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	100,281	9,727,891	0.010309	6,965	72	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	38,562	34,837,691	0.001107	358,112	396	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,615	35,989,313	0.001434	650	1	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	415,658	119,138,311	0.003489	1,793,709	6,258	73.00
74.00	07400	RENAL DIALYSIS	3,705	3,929,673	0.000943	154,287	145	74.00
76.97	07697	CARDIAC REHABILITATION	165,379	2,040,795	0.081037	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	295,192	6,729,049	0.043868	0	0	90.00
91.00	09100	EMERGENCY	568,535	97,040,446	0.005859	5,985	35	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	14,815,523	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	12,630,823	1,070,974,277		7,584,224	65,312	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Prepared: 11/23/2021 10:33 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	36,327	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	437,057	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	473,384	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Prepared: 11/23/2021 10:33 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7) (see instructions)	
	4.00	5.00	6.00	7.00	8.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	36,327	36,327	156,113,456	0.000233	50.00
51.00 05100 RECOVERY ROOM	0	0	0	19,861,864	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	3,961,432	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	30,208,580	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	61,198,624	0.000000	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0	18,814,637	0.000000	55.00
56.00 05600 RADIOISOTOPE	0	0	0	18,898,031	0.000000	56.00
57.00 05700 CT SCAN	0	0	0	83,214,033	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	35,810,735	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	84,084,840	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	150,129,358	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0.000000	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	6,062,639	0.000000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	3,904,638	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	14,711,344	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	18,691,954	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	6,871,114	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	1,459,228	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	32,729,078	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	9,727,891	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	34,837,691	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,989,313	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	119,138,311	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	3,929,673	0.000000	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	2,040,795	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	6,729,049	0.000000	90.00
91.00 09100 EMERGENCY	0	437,057	437,057	97,040,446	0.004504	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	14,815,523	0.000000	92.00
200.00 Total (lines 50 through 199)	0	473,384	473,384	1,070,974,277		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0034 Component CCN: 15-T034		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/23/2021 10:33 am	
				Title XVIII		Subprovider - IRF	PPS
Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0.000233	69,928	16	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	5,684	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	7,069	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	147,109	0	911	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	56,059	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	11,663	0	0	56.00
57.00	05700	CT SCAN	0.000000	193,462	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	46,362	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	23,053	0	0	59.00
60.00	06000	LABORATORY	0.000000	685,816	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	18,365	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	412,869	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,658,733	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,637,071	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	233,688	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	57,585	0	696	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	6,965	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	358,112	0	1,402	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	650	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,793,709	0	877	73.00
74.00	07400	RENAL DIALYSIS	0.000000	154,287	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.004504	5,985	27	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	92.00
200.00		Total (lines 50 through 199)		7,584,224	43	3,886	200.00



APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Prepared: 11/23/2021 10:33 am
Title XVIII			Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0.230905	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.321562	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.527749	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.026946	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140301	911	0	128	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.108214	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.126645	0	0	0	56.00
57.00	05700	CT SCAN	0.043544	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.074608	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.086075	0	0	0	59.00
60.00	06000	LABORATORY	0.104878	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.282847	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.224687	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.276645	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.266127	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.184258	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.402176	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.072403	696	0	50	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.105999	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303267	1,402	0	425	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.405354	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.180231	877	0	158	73.00
74.00	07400	RENAL DIALYSIS	0.252049	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.630526	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0.479587	0	0	0	90.00
91.00	09100	EMERGENCY	0.114707	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.296369	0	0	0	92.00
200.00		Subtotal (see instructions)		3,886	0	761	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 - line 201)		3,886	0	761	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Prepared: 11/23/2021 10:33 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part I Date/Time Prepared: 11/23/2021 10:33 am
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Cost Center Description		Title XIX			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,417,058	0	2,417,058	41,217	58.64	30.00
31.00	INTENSIVE CARE UNIT	642,010		642,010	5,136	125.00	31.00
41.00	SUBPROVIDER - IRF	298,161	0	298,161	5,437	54.84	41.00
43.00	NURSERY	119,008		119,008	1,434	82.99	43.00
200.00	Total (lines 30 through 199)	3,476,237		3,476,237	53,224		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	933	54,711				
31.00	INTENSIVE CARE UNIT	18	2,250				
41.00	SUBPROVIDER - IRF	44	2,413				
43.00	NURSERY	98	8,133				
200.00	Total (lines 30 through 199)	1,093	67,507				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0034

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

Worksheet D  
Part II  
Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,570,608	156,113,456	0.029277	317,856	9,306	50.00
51.00	05100	RECOVERY ROOM	487,355	19,861,864	0.024537	33,898	832	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	392,845	3,961,432	0.099167	23,672	2,347	52.00
53.00	05300	ANESTHESIOLOGY	12,801	30,208,580	0.000424	64,757	27	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	932,112	61,198,624	0.015231	79,922	1,217	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	240,473	18,814,637	0.012781	0	0	55.00
56.00	05600	RADIOISOTOPE	236,233	18,898,031	0.012500	47,209	590	56.00
57.00	05700	CT SCAN	198,684	83,214,033	0.002388	361,368	863	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	637,581	35,810,735	0.017804	55,368	986	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,733,012	84,084,840	0.020610	89,164	1,838	59.00
60.00	06000	LABORATORY	442,452	150,129,358	0.002947	671,739	1,980	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.000000	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	54,052	6,062,639	0.008916	16,300	145	63.00
64.00	06400	INTRAVENOUS THERAPY	73,065	3,904,638	0.018712	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	177,077	14,711,344	0.012037	141,092	1,698	65.00
66.00	06600	PHYSICAL THERAPY	403,943	18,691,954	0.021611	23,163	501	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,729	6,871,114	0.003890	15,393	60	67.00
68.00	06800	SPEECH PATHOLOGY	8,367	1,459,228	0.005734	17,078	98	68.00
69.00	06900	ELECTROCARDIOLOGY	364,507	32,729,078	0.011137	126,511	1,409	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	100,281	9,727,891	0.010309	17,591	181	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	38,562	34,837,691	0.001107	172,267	191	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,615	35,989,313	0.001434	41,519	60	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	415,658	119,138,311	0.003489	787,837	2,749	73.00
74.00	07400	RENAL DIALYSIS	3,705	3,929,673	0.000943	68,978	65	74.00
76.97	07697	CARDIAC REHABILITATION	165,379	2,040,795	0.081037	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	295,192	6,729,049	0.043868	0	0	90.00
91.00	09100	EMERGENCY	568,535	97,040,446	0.005859	332,221	1,946	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	298,842	14,815,523	0.020171	34,198	690	92.00
200.00		Total (lines 50 through 199)	12,929,665	1,070,974,277		3,539,101	29,779	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part III Date/Time Prepared: 11/23/2021 10:33 am
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Cost Center Description			Title XIX		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	41,217	0.00	933	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	5,136	0.00	18	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	5,437	0.00	44	41.00
43.00	04300	NURSERY	0	0	1,434	0.00	98	43.00
200.00		Total (lines 30 through 199)	0	0	53,224		1,093	200.00
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
			9.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0					31.00
41.00	04100	SUBPROVIDER - IRF	0					41.00
43.00	04300	NURSERY	0					43.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description		Title XIX			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	36,327	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	437,057	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	473,384	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description		Title XIX			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)		
		4.00	5.00	6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	36,327	36,327	156,113,456	0.000233	50.00
51.00	05100	RECOVERY ROOM	0	0	0	19,861,864	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,961,432	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	30,208,580	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	61,198,624	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	18,814,637	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	18,898,031	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	83,214,033	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	35,810,735	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	84,084,840	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	150,129,358	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	6,062,639	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,904,638	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,711,344	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	18,691,954	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,871,114	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,459,228	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	32,729,078	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	9,727,891	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	34,837,691	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,989,313	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	119,138,311	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,929,673	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,040,795	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	6,729,049	0.000000	90.00
91.00	09100	EMERGENCY	0	437,057	437,057	97,040,446	0.004504	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	14,815,523	0.000000	92.00
200.00		Total (lines 50 through 199)	0	473,384	473,384	1,070,974,277		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description		Title XIX			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000233	317,856	74	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	33,898	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	23,672	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	64,757	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	79,922	0	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	47,209	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	361,368	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	55,368	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	89,164	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	671,739	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000	16,300	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	141,092	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	23,163	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	15,393	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	17,078	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	126,511	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	17,591	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	172,267	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	41,519	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	787,837	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	68,978	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.004504	332,221	1,496	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	34,198	0	0	0	92.00
200.00	Total (lines 50 through 199)		3,539,101	1,570	0	0	200.00



APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Prepared: 11/23/2021 10:33 am
	Title XIX	Subprovider - IRF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	4,570,608	156,113,456	0.029277	0	0	50.00
51.00	05100 RECOVERY ROOM	487,355	19,861,864	0.024537	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	392,845	3,961,432	0.099167	0	0	52.00
53.00	05300 ANESTHESIOLOGY	12,801	30,208,580	0.000424	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	932,112	61,198,624	0.015231	1,088	17	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	240,473	18,814,637	0.012781	0	0	55.00
56.00	05600 RADIOISOTOPE	236,233	18,898,031	0.012500	0	0	56.00
57.00	05700 CT SCAN	198,684	83,214,033	0.002388	3,169	8	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	637,581	35,810,735	0.017804	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,733,012	84,084,840	0.020610	0	0	59.00
60.00	06000 LABORATORY	442,452	150,129,358	0.002947	4,057	12	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	54,052	6,062,639	0.008916	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	73,065	3,904,638	0.018712	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	177,077	14,711,344	0.012037	1,475	18	65.00
66.00	06600 PHYSICAL THERAPY	403,943	18,691,954	0.021611	12,998	281	66.00
67.00	06700 OCCUPATIONAL THERAPY	26,729	6,871,114	0.003890	11,886	46	67.00
68.00	06800 SPEECH PATHOLOGY	8,367	1,459,228	0.005734	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	364,507	32,729,078	0.011137	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	100,281	9,727,891	0.010309	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	38,562	34,837,691	0.001107	3,136	3	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	51,615	35,989,313	0.001434	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	415,658	119,138,311	0.003489	25,458	89	73.00
74.00	07400 RENAL DIALYSIS	3,705	3,929,673	0.000943	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	165,379	2,040,795	0.081037	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	295,192	6,729,049	0.043868	0	0	90.00
91.00	09100 EMERGENCY	568,535	97,040,446	0.005859	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	14,815,523	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	12,630,823	1,070,974,277		63,267	474	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Prepared: 11/23/2021 10:33 am
Title XIX		Subprovider - IRF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	0	36,327	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	437,057	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	473,384	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Prepared: 11/23/2021 10:33 am
Title XIX		Subprovider - IRF	PPS

Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7) (see instructions)	
	4.00	5.00	6.00	7.00	8.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	36,327	36,327	156,113,456	0.000233	50.00
51.00 05100 RECOVERY ROOM	0	0	0	19,861,864	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	3,961,432	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	30,208,580	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	61,198,624	0.000000	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0	18,814,637	0.000000	55.00
56.00 05600 RADIOISOTOPE	0	0	0	18,898,031	0.000000	56.00
57.00 05700 CT SCAN	0	0	0	83,214,033	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	35,810,735	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	84,084,840	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	150,129,358	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0.000000	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	6,062,639	0.000000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	3,904,638	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	14,711,344	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	18,691,954	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	6,871,114	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	1,459,228	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	32,729,078	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	9,727,891	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	34,837,691	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,989,313	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	119,138,311	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	3,929,673	0.000000	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	2,040,795	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	6,729,049	0.000000	90.00
91.00 09100 EMERGENCY	0	437,057	437,057	97,040,446	0.004504	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	14,815,523	0.000000	92.00
200.00 Total (lines 50 through 199)	0	473,384	473,384	1,070,974,277		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Prepared: 11/23/2021 10:33 am
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Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000233	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	1,088	0	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	3,169	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	4,057	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	1,475	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	12,998	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	11,886	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,136	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	25,458	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.004504	0	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)		63,267	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/23/2021 10:33 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		41,217	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		41,217	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		36,121	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		15,204	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		35,513,861	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		35,513,861	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		35,513,861	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		861.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		13,100,223	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		13,100,223	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/23/2021 10:33 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	
42.00	Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42.00
43.00	INTENSIVE CARE UNIT	8,678,710	5,136	1,689.78	1,795	3,033,155	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)					23,078,487	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					39,211,865	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,115,938	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,341,816	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,457,754	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					36,754,111	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					5,096	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					861.63	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,390,866	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/23/2021 10:33 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,417,058	35,513,861	0.068060	4,390,866	298,842	90.00
91.00	Nursing School cost	0	35,513,861	0.000000	4,390,866	0	91.00
92.00	Allied health cost	0	35,513,861	0.000000	4,390,866	0	92.00
93.00	All other Medical Education	0	35,513,861	0.000000	4,390,866	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/23/2021 10:33 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,437	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,437	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)		5,437	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		3,441	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,313,387	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,313,387	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,313,387	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		977.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,362,752	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)		3,362,752	41.00



COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034 Component CCN: 15-T034		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/23/2021 10:33 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,565,403	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,928,155	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)					188,704	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					65,355	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					254,059	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,674,096	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034 Component CCN: 15-T034		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/23/2021 10:33 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	298,161	5,313,387	0.056115	0	0	90.00
91.00	Nursing School cost	0	5,313,387	0.000000	0	0	91.00
92.00	Allied health cost	0	5,313,387	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,313,387	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/23/2021 10:33 am
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		41,217	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		41,217	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		36,121	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		933	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,434	15.00
16.00	Nursery days (title V or XIX only)		98	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		35,513,861	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		35,513,861	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		35,513,861	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		861.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		803,901	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)		803,901	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/23/2021 10:33 am
Title XIX			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
42.00 NURSERY (title V & XIX only)	2,511,750	1,434	1,751.57	98	171,654
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	8,678,710	5,136	1,689.78	18	30,416
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					561,126
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,567,097
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					65,094
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					31,349
52.00 Total Program excludable cost (sum of lines 50 and 51)					96,443
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,470,654
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00 Program routine service cost (line 9 x line 71)					
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00 Per diem capital-related costs (line 75 ÷ line 2)					
77.00 Program capital-related costs (line 9 x line 76)					
78.00 Inpatient routine service cost (line 74 minus line 77)					
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00 Inpatient routine service cost per diem limitation					
82.00 Inpatient routine service cost limitation (line 9 x line 81)					
83.00 Reasonable inpatient routine service costs (see instructions)					
84.00 Program inpatient ancillary services (see instructions)					
85.00 Utilization review - physician compensation (see instructions)					
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					5,096
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					861.63
89.00 Observation bed cost (line 87 x line 88) (see instructions)					4,390,866

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/23/2021 10:33 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,417,058	35,513,861	0.068060	4,390,866	298,842	90.00
91.00	Nursing School cost	0	35,513,861	0.000000	4,390,866	0	91.00
92.00	Allied health cost	0	35,513,861	0.000000	4,390,866	0	92.00
93.00	All other Medical Education	0	35,513,861	0.000000	4,390,866	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/23/2021 10:33 am
		Title XIX	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			5,437 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			5,437 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)			5,437 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			44 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)			1,434 15.00
16.00	Nursery days (title V or XIX only)			98 16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			5,313,387 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			5,313,387 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			5,313,387 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			977.26 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			42,999 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)			42,999 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034 Component CCN: 15-T034		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/23/2021 10:33 am	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					12,313	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					55,312	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)					2,413	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					474	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,887	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					52,425	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034 Component CCN: 15-T034		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/23/2021 10:33 am	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	298,161	5,313,387	0.056115	0	0	90.00
91.00	Nursing School cost	0	5,313,387	0.000000	0	0	91.00
92.00	Allied health cost	0	5,313,387	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,313,387	0.000000	0	0	93.00



INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/23/2021 10:33 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		25,887,400	30.00
31.00	03100	INTENSIVE CARE UNIT		5,203,405	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.231021	16,722,426	50.00
51.00	05100	RECOVERY ROOM	0.321562	1,847,635	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.527749	0	52.00
53.00	05300	ANESTHESIOLOGY	0.026946	3,185,479	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140439	3,499,931	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.108214	88,266	55.00
56.00	05600	RADIOISOTOPE	0.126645	1,137,421	56.00
57.00	05700	CT SCAN	0.043544	9,127,027	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.074608	2,210,399	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.086130	9,892,473	59.00
60.00	06000	LABORATORY	0.105044	16,923,053	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.282847	1,328,948	63.00
64.00	06400	INTRAVENOUS THERAPY	0.224687	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.276658	5,166,665	65.00
66.00	06600	PHYSICAL THERAPY	0.266127	1,352,055	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.184258	868,691	67.00
68.00	06800	SPEECH PATHOLOGY	0.402176	205,286	68.00
69.00	06900	ELECTROCARDIOLOGY	0.072466	3,342,772	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.106348	175,478	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303267	6,825,062	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.405354	8,786,918	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.180231	22,482,092	73.00
74.00	07400	RENAL DIALYSIS	0.252049	1,590,857	74.00
76.97	07697	CARDIAC REHABILITATION	0.630526	112,898	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.483386	83,686	90.00
91.00	09100	EMERGENCY	0.114707	13,127,160	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.296369	1,105,047	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		131,187,725	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		131,187,725	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/23/2021 10:33 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF		4,888,647		41.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.231021	69,928	16,155	50.00
51.00	05100 RECOVERY ROOM	0.321562	5,684	1,828	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.527749	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.026946	7,069	190	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.140439	147,109	20,660	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.108214	56,059	6,066	55.00
56.00	05600 RADIOISOTOPE	0.126645	11,663	1,477	56.00
57.00	05700 CT SCAN	0.043544	193,462	8,424	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.074608	46,362	3,459	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.086130	23,053	1,986	59.00
60.00	06000 LABORATORY	0.105044	685,816	72,041	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.282847	18,365	5,194	63.00
64.00	06400 INTRAVENOUS THERAPY	0.224687	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.276658	412,869	114,224	65.00
66.00	06600 PHYSICAL THERAPY	0.266127	1,658,733	441,434	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.184258	1,637,071	301,643	67.00
68.00	06800 SPEECH PATHOLOGY	0.402176	233,688	93,984	68.00
69.00	06900 ELECTROCARDIOLOGY	0.072466	57,585	4,173	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.106348	6,965	741	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.303267	358,112	108,604	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.405354	650	263	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.180231	1,793,709	323,282	73.00
74.00	07400 RENAL DIALYSIS	0.252049	154,287	38,888	74.00
76.97	07697 CARDIAC REHABILITATION	0.630526	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.483386	0	0	90.00
91.00	09100 EMERGENCY	0.114707	5,985	687	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.296369	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		7,584,224	1,565,403	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		7,584,224		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/23/2021 10:33 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		1,051,300	30.00
31.00	03100	INTENSIVE CARE UNIT		174,460	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		312,906	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.231021	317,856	50.00
51.00	05100	RECOVERY ROOM	0.321562	33,898	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.527749	23,672	52.00
53.00	05300	ANESTHESIOLOGY	0.026946	64,757	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140439	79,922	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.108214	0	55.00
56.00	05600	RADIOISOTOPE	0.126645	47,209	56.00
57.00	05700	CT SCAN	0.043544	361,368	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.074608	55,368	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.086130	89,164	59.00
60.00	06000	LABORATORY	0.105044	671,739	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.282847	16,300	63.00
64.00	06400	INTRAVENOUS THERAPY	0.224687	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.276658	141,092	65.00
66.00	06600	PHYSICAL THERAPY	0.266127	23,163	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.184258	15,393	67.00
68.00	06800	SPEECH PATHOLOGY	0.402176	17,078	68.00
69.00	06900	ELECTROCARDIOLOGY	0.072466	126,511	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.106348	17,591	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303267	172,267	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.405354	41,519	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.180231	787,837	73.00
74.00	07400	RENAL DIALYSIS	0.252049	68,978	74.00
76.97	07697	CARDIAC REHABILITATION	0.630526	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.483386	0	90.00
91.00	09100	EMERGENCY	0.114707	332,221	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.296369	34,198	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,539,101	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		3,539,101	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/23/2021 10:33 am	
		Title XIX	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF		34,773		41.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.231021	0	0	50.00
51.00	05100 RECOVERY ROOM	0.321562	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.527749	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.026946	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.140439	1,088	153	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.108214	0	0	55.00
56.00	05600 RADIOISOTOPE	0.126645	0	0	56.00
57.00	05700 CT SCAN	0.043544	3,169	138	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.074608	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.086130	0	0	59.00
60.00	06000 LABORATORY	0.105044	4,057	426	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.282847	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.224687	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.276658	1,475	408	65.00
66.00	06600 PHYSICAL THERAPY	0.266127	12,998	3,459	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.184258	11,886	2,190	67.00
68.00	06800 SPEECH PATHOLOGY	0.402176	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.072466	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.106348	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.303267	3,136	951	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.405354	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.180231	25,458	4,588	73.00
74.00	07400 RENAL DIALYSIS	0.252049	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.630526	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.483386	0	0	90.00
91.00	09100 EMERGENCY	0.114707	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.296369	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		63,267	12,313	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		63,267		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/23/2021 10:33 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		9,361,977	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		26,901,856	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		107,925	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		224,508	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		166.03	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
<b>Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.43	30.00
31.00	Percentage of Medicaid patient days (see instructions)		15.99	31.00
32.00	Sum of lines 30 and 31		19.42	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.37	33.00
34.00	Disproportionate share adjustment (see instructions)		486,843	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/23/2021 10:33 am	
		Title XVIII	Hospital	PPS	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)	8,350,599,096	8,290,014,521	35.00	
35.01	Factor 3 (see instructions)	0.000167267	0.000197202	35.01	
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,396,784	1,634,811	35.02	
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	351,104	1,222,749	35.03	
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,573,853		36.00	
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	40.00	
		Before 1/1	On/After 1/1		
		1.00	1.01		
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.01	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00	
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00	
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	46.00	
47.00	Subtotal (see instructions)	38,656,962		47.00	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00	
			Amount		
			1.00		
49.00	Total payment for inpatient operating costs (see instructions)		38,656,962	49.00	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,937,178	50.00	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00	
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00	
53.00	Nursing and Allied Health Managed Care payment		39,320	53.00	
54.00	Special add-on payments for new technologies		130,331	54.00	
54.01	Islet isolation add-on payment		0	54.01	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00	
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00	
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00	
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		63,021	58.00	
59.00	Total (sum of amounts on lines 49 through 58)		41,826,812	59.00	
60.00	Primary payer payments		3,358	60.00	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		41,823,454	61.00	
62.00	Deductibles billed to program beneficiaries		3,448,420	62.00	
63.00	Coinurance billed to program beneficiaries		179,731	63.00	
64.00	Allowable bad debts (see instructions)		374,821	64.00	
65.00	Adjusted reimbursable bad debts (see instructions)		243,634	65.00	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		65,281	66.00	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		38,438,937	67.00	
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00	
70.00	ADD BACK GME REIMBURSEMENT		0	70.00	
70.01	OTHER ADJ (NO DESC ENTERED)		0	70.01	
70.02	OTHER ADJUSTMENTS PER PSR		0	70.02	
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50	
70.87	Demonstration payment adjustment amount before sequestration		0	70.87	
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88	
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89	
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90	
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91	
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92	
70.93	HVBP payment adjustment amount (see instructions)		82,009	70.93	
70.94	HRR adjustment amount (see instructions)		-994,168	70.94	
70.95	Recovery of accelerated depreciation		0	70.95	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/23/2021 10:33 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)		Amount	
		0		1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			37,526,778	71.00
71.01	Sequestration adjustment (see instructions)			0	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			0	71.03
72.00	Interim payments			37,133,003	72.00
72.01	Interim payments-PARHM				72.01
73.00	Tentative settlement (for contractor use only)			0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)				73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			393,775	74.00
74.01	Balance due provider/program-PARHM (see instructions)				74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			862,378	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)				90.00
91.00	Capital outlier from Wkst. L, Pt. 1, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
<b>HSP Bonus Payment Amount</b>					
100.00	HSP bonus amount (see instructions)			0	100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
<b>HRR Adjustment for HSP Bonus Payment</b>					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
<b>Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment</b>					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
<b>Cost Reimbursement</b>					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. 11, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
<b>Adjustment to Medicare Part A Inpatient Reimbursement</b>					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
<b>Comparison of PPS versus Cost Reimbursement</b>					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/23/2021 10:33 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		23,018	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		28,713,481	2.00
3.00	OPPS payments		29,751,140	3.00
4.00	Outlier payment (see instructions)		28,146	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		57,289	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		23,018	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		116,990	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)		116,990	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		116,990	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		93,972	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)		23,018	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)		29,836,575	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		5,452,469	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)		24,407,124	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)		24,407,124	30.00
31.00	Primary payer payments		14,193	31.00
32.00	Subtotal (line 30 minus line 31)		24,392,931	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		591,715	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		384,615	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		274,165	36.00
37.00	Subtotal (see instructions)		24,777,546	37.00
38.00	MSP-LCC reconciliation amount from PS&R		57	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)		24,777,489	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		24,765,538	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)		11,951	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00



CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/23/2021 10:33 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		761	2.00
3.00	OPPS payments		155	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)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		155	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		31	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)		124	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)		124	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		124	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		124	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		124	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		124	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)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0034

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/23/2021 10:33 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		36,745,587		24,334,077	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		387,416		431,461	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		37,133,003		24,765,538	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		393,775		11,951	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		37,526,778		24,777,489	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: 15-0034 Component CCN: 15-T034	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part I Date/Time Prepared: 11/23/2021 10:33 am	
		Title XVIII	Subprovider - IRF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				
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		6,501,775		124
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)		0		0
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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)		6,501,775		124
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		80,115		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		6,581,890		124
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part II Date/Time Prepared: 11/23/2021 10:33 am
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part III Date/Time Prepared: 11/23/2021 10:33 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)			6,414,382 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0284 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			240,539 3.00
4.00	Outlier Payments			48,270 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			14.895890 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			6,703,191 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			6,703,191 17.00
18.00	Primary payer payments			35,393 18.00
19.00	Subtotal (line 17 less line 18).			6,667,798 19.00
20.00	Deductibles			39,004 20.00
21.00	Subtotal (line 19 minus line 20)			6,628,794 21.00
22.00	Coinsurance			46,947 22.00
23.00	Subtotal (line 21 minus line 22)			6,581,847 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			6,581,847 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			43 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			6,581,890 32.00
32.01	Sequestration adjustment (see instructions)			0 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			6,501,775 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			80,115 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			48,270 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/23/2021 10:33 am	
		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		1,538,666		8.00
9.00	Ancillary service charges		3,539,101	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		5,077,767	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		5,077,767	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		5,077,767	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		1,570	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		1,570	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		1,570	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1,570	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		1,570	0	36.00
37.00	TO ZERO OUT SETTLEMENT, SINCE NO ADD		-1,570	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/23/2021 10:33 am	
		Title XIX	Subprovider - IRF	PPS	
				Inpatient 1.00	Outpatient 2.00
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		63,267	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		63,267	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		63,267	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		63,267	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	TO ZERO OUT SETTLEMENT		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 15-0034

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

Worksheet G

Date/Time Prepared:  
11/23/2021 10:33 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	2,898	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	34,966,257	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	9,253,981	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	2,308,704	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	46,531,840	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	122,930,218	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	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)	122,930,218	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	10,234,844	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,234,844	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	179,696,902	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	1,567,261	0	0	0	37.00
38.00	Salaries, wages, and fees payable	10,355,032	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	38,344,507	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	50,266,800	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	15,116,622	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,116,622	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	65,383,422	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	114,313,480	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)	114,313,480	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	179,696,902	0	0	0	60.00



STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0034

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

Worksheet G-1

Date/Time Prepared:  
11/23/2021 10:33 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		118,646,590		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		53,140,791			2.00
3.00	Total (sum of line 1 and line 2)		171,787,381		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00	NET ASSETS RELEASED	6,000		0		5.00
6.00	CONTRIBUTIONS	41,000		0		6.00
7.00	ROUNDING	99		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		47,099		0	10.00
11.00	Subtotal (line 3 plus line 10)		171,834,480		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00	TRANSFER FUNDS	57,487,000		0		13.00
14.00	ASSETS RELEASED	34,000		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		57,521,000		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		114,313,480		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	NET ASSETS RELEASED		0			5.00
6.00	CONTRIBUTIONS		0			6.00
7.00	ROUNDING		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	TRANSFER FUNDS		0			13.00
14.00	ASSETS RELEASED		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: 15-0034

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/23/2021 10:33 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	66,884,485		66,884,485	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	7,510,355		7,510,355	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	74,394,840		74,394,840	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	14,980,273		14,980,273	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)	14,980,273		14,980,273	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	89,375,113		89,375,113	17.00
18.00	Ancillary services	339,946,810		339,946,810	18.00
19.00	Outpatient services	0	732,080,253	732,080,253	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		4,603,231	4,603,231	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	PHYSICIAN OFFICES	557	1,226,934	1,227,491	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	429,322,480	737,910,418	1,167,232,898	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		261,614,909		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBTS	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)		261,614,909		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet G-3 Date/Time Prepared: 11/23/2021 10:33 am
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,167,232,898	1.00
2.00	Less contractual allowances and discounts on patients' accounts	861,961,707	2.00
3.00	Net patient revenues (line 1 minus line 2)	305,271,191	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	261,614,909	4.00
5.00	Net income from service to patients (line 3 minus line 4)	43,656,282	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	477,495	6.00
7.00	Income from investments	132,794	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	864,021	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	6,017	21.00
22.00	Rental of hospital space	1,053,349	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	94,457	24.00
24.02	RELEASED TEMP ASSETS	28,486	24.02
24.03	UBI INCOME	184,311	24.03
24.05	CLASSES	37,774	24.05
24.07	GAIN ON SALE OF ASSETS	57,376	24.07
24.08	ROUNDING	0	24.08
24.50	COVID-19 PHE Funding	6,548,429	24.50
25.00	Total other income (sum of lines 6-24)	9,484,509	25.00
26.00	Total (line 5 plus line 25)	53,140,791	26.00
27.00	ROUNDING	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)	53,140,791	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0034

Period: From 07/01/2020

Worksheet H

HHA CCN: 15-7313

To 06/30/2021

Date/Time Prepared: 11/23/2021 10:33 am

Home Health Agency I

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	789,935	84,112	0	17,727	39,742	931,516	5.00
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	726,698	77,378	58,611	0	1,466	864,153	6.00
7.00	Physical Therapy	634,322	67,542	21,799	299	0	723,962	7.00
8.00	Occupational Therapy	147,860	15,744	1,879	0	0	165,483	8.00
9.00	Speech Pathology	23,547	2,507	256	18,976	0	45,286	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	94,705	10,084	22,756	0	0	127,545	11.00
12.00	Supplies (see instructions)	0	0	0	0	113,167	113,167	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,417,067	257,367	105,301	37,002	154,375	2,971,112	24.00
		Reclassified	Reclassified	Adjustments	Net Expenses			
		7.00	8.00	9.00	10.00			
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-135	931,381	-485	930,896			5.00
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	0	864,153	0	864,153			6.00
7.00	Physical Therapy	0	723,962	0	723,962			7.00
8.00	Occupational Therapy	0	165,483	0	165,483			8.00
9.00	Speech Pathology	0	45,286	0	45,286			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	127,545	0	127,545			11.00
12.00	Supplies (see instructions)	0	113,167	0	113,167			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Tel emedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-135	2,970,977	-485	2,970,492			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet H-1 Part I Date/Time Prepared: 11/23/2021 10:33 am
		HHA CCN: 15-7313	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	930,896	0	0	0	930,896	5.00	
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	864,153	0	0	0	864,153	6.00	
7.00	Physical Therapy	723,962	0	0	0	723,962	7.00	
8.00	Occupational Therapy	165,483	0	0	0	165,483	8.00	
9.00	Speech Pathology	45,286	0	0	0	45,286	9.00	
10.00	Medical Social Services	0	0	0	0	0	10.00	
11.00	Home Health Aide	127,545	0	0	0	127,545	11.00	
12.00	Supplies (see instructions)	113,167	0	0	0	113,167	12.00	
13.00	Drugs	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	2,970,492	0	0	0	2,970,492	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	930,896					5.00	
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	394,410	1,258,563				6.00	
7.00	Physical Therapy	330,425	1,054,387				7.00	
8.00	Occupational Therapy	75,528	241,011				8.00	
9.00	Speech Pathology	20,669	65,955				9.00	
10.00	Medical Social Services	0	0				10.00	
11.00	Home Health Aide	58,213	185,758				11.00	
12.00	Supplies (see instructions)	51,651	164,818				12.00	
13.00	Drugs	0	0				13.00	
14.00	DME	0	0				14.00	
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
23.50	Telemedicine	0	0				23.50	
24.00	Total (sum of lines 1-23)		2,970,492				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0034

Period: From 07/01/2020

Worksheet H-1

HHA CCN: 15-7313

To 06/30/2021

Part II  
Date/Time Prepared: 11/23/2021 10:33 am

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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-930,896	2,039,596
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	0	0	0	0	864,153
7.00	Physical Therapy	0	0	0	0	0	723,962
8.00	Occupational Therapy	0	0	0	0	0	165,483
9.00	Speech Pathology	0	0	0	0	0	45,286
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	127,545
12.00	Supplies (see instructions)	0	0	0	0	0	113,167
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-930,896	2,039,596
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		930,896
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.456412

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0034

Period: From 07/01/2020

Worksheet H-2

HHA CCN: 15-7313

To 06/30/2021

Part I Date/Time Prepared: 11/23/2021 10:33 am

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	PURCHASING RECEIVING AND STORES	ADMITTING	
		BLDG & FIXT	MVBLE EQUIP					
		1.00	2.00	4.00				
	0				5.01	5.02		
1.00 Administrative and General	0	0	2,878	147,232	59	12,615	1.00	
2.00 Skilled Nursing Care	1,258,563	0	0	135,446	0	0	2.00	
3.00 Physical Therapy	1,054,387	0	0	118,229	0	0	3.00	
4.00 Occupational Therapy	241,011	0	0	27,559	0	0	4.00	
5.00 Speech Pathology	65,955	0	0	4,389	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	185,758	0	0	17,652	0	0	7.00	
8.00 Supplies (see instructions)	164,818	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
19.50 Telemedicine	0	0	0	0	0	0	19.50	
20.00 Total (sum of lines 1-19) (2)	2,970,492	0	2,878	450,507	59	12,615	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00	
Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
	5.03	5A.03	5.04	7.00	8.00	9.00		
1.00 Administrative and General	11,842	174,626	25,557	0	0	0	1.00	
2.00 Skilled Nursing Care	0	1,394,009	204,016	0	0	0	2.00	
3.00 Physical Therapy	0	1,172,616	171,615	0	0	0	3.00	
4.00 Occupational Therapy	0	268,570	39,306	0	0	0	4.00	
5.00 Speech Pathology	0	70,344	10,295	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	0	203,410	29,769	0	0	0	7.00	
8.00 Supplies (see instructions)	0	164,818	24,121	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
19.50 Telemedicine	0	0	0	0	0	0	19.50	
20.00 Total (sum of lines 1-19) (2)	11,842	3,448,393	504,679	0	0	0	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.000000					21.00	

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0034

Period: From 07/01/2020

Worksheet H-2

HHA CCN: 15-7313

To 06/30/2021

Part I  
Date/Time Prepared: 11/23/2021 10:33 am

Home Health Agency I

PPS

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	10,498	0	0	0	11,943	1.00
2.00	Skilled Nursing Care	0	6,414	0	0	0	0	2.00
3.00	Physical Therapy	0	3,361	0	0	0	0	3.00
4.00	Occupational Therapy	0	1,391	0	0	0	0	4.00
5.00	Speech Pathology	0	271	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	2,765	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	24,700	0	0	0	11,943	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	PARAMEDICAL EDUCATION PROGRAM EMS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		17.00	19.00	23.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	0	222,624	0	222,624	1.00
2.00	Skilled Nursing Care	0	0	0	1,604,439	0	1,604,439	2.00
3.00	Physical Therapy	0	0	0	1,347,592	0	1,347,592	3.00
4.00	Occupational Therapy	0	0	0	309,267	0	309,267	4.00
5.00	Speech Pathology	0	0	0	80,910	0	80,910	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	235,944	0	235,944	7.00
8.00	Supplies (see instructions)	0	0	0	188,939	0	188,939	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	3,989,715	0	3,989,715	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.



ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 15-0034 HHA CCN: 15-7313	Period: From 07/01/2020 To 06/30/2021	Worksheet H-2 Part I Date/Time Prepared: 11/23/2021 10:33 am PPS
			Home Health Agency I	

Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs		
		27.00	28.00		
1.00	Administrative and General				1.00
2.00	Skilled Nursing Care	94,816	1,699,255		2.00
3.00	Physical Therapy	79,639	1,427,231		3.00
4.00	Occupational Therapy	18,277	327,544		4.00
5.00	Speech Pathology	4,782	85,692		5.00
6.00	Medical Social Services	0	0		6.00
7.00	Home Health Aide	13,944	249,888		7.00
8.00	Supplies (see instructions)	11,166	200,105		8.00
9.00	Drugs	0	0		9.00
10.00	DME	0	0		10.00
11.00	Home Dialysis Aide Services	0	0		11.00
12.00	Respiratory Therapy	0	0		12.00
13.00	Private Duty Nursing	0	0		13.00
14.00	Clinic	0	0		14.00
15.00	Health Promotion Activities	0	0		15.00
16.00	Day Care Program	0	0		16.00
17.00	Home Delivered Meals Program	0	0		17.00
18.00	Homemaker Service	0	0		18.00
19.00	All Others (specify)	0	0		19.00
19.50	Telemedicine	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	222,624	3,989,715		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.059097			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0034  
HHA CCN: 15-7313

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

Worksheet H-2  
Part II  
Date/Time Prepared: 11/23/2021 10:33 am  
PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING RECEIVING AND STORES (COSTED REQ)	ADMITTING (GROSS REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	0	6,723	789,935	80	4,602,391	4,602,391	1.00
2.00 Skilled Nursing Care	0	0	726,698	0	0	0	2.00
3.00 Physical Therapy	0	0	634,322	0	0	0	3.00
4.00 Occupational Therapy	0	0	147,860	0	0	0	4.00
5.00 Speech Pathology	0	0	23,547	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	94,705	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	6,723	2,417,067	80	4,602,391	4,602,391	20.00
21.00 Total cost to be allocated	0	2,878	450,507	59	12,615	11,842	21.00
22.00 Unit cost multiplier	0.000000	0.428083	0.186386	0.737500	0.002741	0.002573	22.00
Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
	5A.04	5.04	7.00	8.00	9.00	10.00	
1.00 Administrative and General	0	174,626	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	1,394,009	0	0	0	0	2.00
3.00 Physical Therapy	0	1,172,616	0	0	0	0	3.00
4.00 Occupational Therapy	0	268,570	0	0	0	0	4.00
5.00 Speech Pathology	0	70,344	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	203,410	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	164,818	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	3,448,393	0	0	0	0	20.00
21.00 Total cost to be allocated	0	504,679	0	0	0	0	21.00
22.00 Unit cost multiplier		0.146352	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS		Provider CCN: 15-0034 HHA CCN: 15-7313		Period: From 07/01/2020 To 06/30/2021		Worksheet H-2 Part II Date/Time Prepared: 11/23/2021 10:33 am PPS	
Cost Center Description		CAFETERIA (NUMBER OF FTES)	NURSING ADMINISTRATION (NURSING HO URS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (TIME SPENT)
		11.00	13.00	14.00	15.00	16.00	17.00
1.00	Administrative and General	1,162	0	0	0	4,602,391	0
2.00	Skilled Nursing Care	710	0	0	0	0	0
3.00	Physical Therapy	372	0	0	0	0	0
4.00	Occupational Therapy	154	0	0	0	0	0
5.00	Speech Pathology	30	0	0	0	0	0
6.00	Medical Social Services	0	0	0	0	0	0
7.00	Home Health Aide	306	0	0	0	0	0
8.00	Supplies (see instructions)	0	0	0	0	0	0
9.00	Drugs	0	0	0	0	0	0
10.00	DME	0	0	0	0	0	0
11.00	Home Dialysis Aide Services	0	0	0	0	0	0
12.00	Respiratory Therapy	0	0	0	0	0	0
13.00	Private Duty Nursing	0	0	0	0	0	0
14.00	Clinic	0	0	0	0	0	0
15.00	Health Promotion Activities	0	0	0	0	0	0
16.00	Day Care Program	0	0	0	0	0	0
17.00	Home Delivered Meals Program	0	0	0	0	0	0
18.00	Homemaker Service	0	0	0	0	0	0
19.00	All Others (specify)	0	0	0	0	0	0
19.50	Telemedicine	0	0	0	0	0	0
20.00	Total (sum of lines 1-19)	2,734	0	0	0	4,602,391	0
21.00	Total cost to be allocated	24,700	0	0	0	11,943	0
22.00	Unit cost multiplier	9.034382	0.000000	0.000000	0.000000	0.002595	0.000000
Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PARAMEDICAL EDUCATION PROGRAM EMS (ASSIGNED TIME)				
		19.00	23.00				
1.00	Administrative and General	0	0				
2.00	Skilled Nursing Care	0	0				
3.00	Physical Therapy	0	0				
4.00	Occupational Therapy	0	0				
5.00	Speech Pathology	0	0				
6.00	Medical Social Services	0	0				
7.00	Home Health Aide	0	0				
8.00	Supplies (see instructions)	0	0				
9.00	Drugs	0	0				
10.00	DME	0	0				
11.00	Home Dialysis Aide Services	0	0				
12.00	Respiratory Therapy	0	0				
13.00	Private Duty Nursing	0	0				
14.00	Clinic	0	0				
15.00	Health Promotion Activities	0	0				
16.00	Day Care Program	0	0				
17.00	Home Delivered Meals Program	0	0				
18.00	Homemaker Service	0	0				
19.00	All Others (specify)	0	0				
19.50	Telemedicine	0	0				
20.00	Total (sum of lines 1-19)	0	0				
21.00	Total cost to be allocated	0	0				
22.00	Unit cost multiplier	0.000000	0.000000				

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 15-0034 HHA CCN: 15-7313	Period: From 07/01/2020 To 06/30/2021	Worksheet H-3 Part I Date/Time Prepared: 11/23/2021 10:33 am
				Title XVIII	Home Health Agency I	PPS
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 + col. 4)
	0	1.00	2.00	3.00	4.00	5.00
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation						
1.00	Skilled Nursing Care	2.00	1,699,255		11,312	150.22
2.00	Physical Therapy	3.00	1,427,231	0	7,617	187.37
3.00	Occupational Therapy	4.00	327,544	0	3,184	102.87
4.00	Speech Pathology	5.00	85,692	0	433	197.90
5.00	Medical Social Services	6.00	0	0	0	0.00
6.00	Home Health Aide	7.00	249,888		2,126	117.54
7.00	Total (sum of lines 1-6)		3,789,610	0	24,672	
Program Visits						
Part B						
Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00
Limitation Cost Computation						
8.00	Skilled Nursing Care		23844	0	5,820	8.00
9.00	Physical Therapy		23844	0	3,509	9.00
10.00	Occupational Therapy		23844	0	1,551	10.00
11.00	Speech Pathology		23844	0	207	11.00
12.00	Medical Social Services		23844	0	0	12.00
13.00	Home Health Aide		23844	0	1,187	13.00
14.00	Total (sum of lines 8-13)			0	12,274	14.00
Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 + col. 4)
	0	1.00	2.00	3.00	4.00	5.00
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	8.00	200,105	0	214,576	0.932560
16.00	Cost of Drugs	9.00	0	0	0	0.000000
Program Visits						
Part B						
Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
	6.00	7.00	8.00	9.00	10.00	11.00
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation						
1.00	Skilled Nursing Care	0	5,820		874,280	1.00
2.00	Physical Therapy	0	3,509		657,481	2.00
3.00	Occupational Therapy	0	1,551		159,551	3.00
4.00	Speech Pathology	0	207		40,965	4.00
5.00	Medical Social Services	0	0		0	5.00
6.00	Home Health Aide	0	1,187		139,520	6.00
7.00	Total (sum of lines 1-6)	0	12,274		1,871,797	7.00
Cost Center Description						
	6.00	7.00	8.00	9.00	10.00	11.00
Limitation Cost Computation						
8.00	Skilled Nursing Care					8.00
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 15-0034 HHA CCN: 15-7313		Period: From 07/01/2020 To 06/30/2021		Worksheet H-3 Part I Date/Time Prepared: 11/23/2021 10:33 am	
				Title XVIII		Home Health Agency I		PPS	
Cost Center Description	Program Covered Charges			Cost of Services					
	Part A	Part B			Part A	Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	6.00	7.00	8.00	9.00	10.00	11.00			
<b>Supplies and Drugs Cost Computations</b>									
15.00	Cost of Medical Supplies	0	194,058	0	0	180,971	0	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description		Total Program Cost (sum of col.s. 9-10)							
		12.00							
<b>PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION</b>									
<b>Cost Per Visit Computation</b>									
1.00	Skilled Nursing Care	874,280						1.00	
2.00	Physical Therapy	657,481						2.00	
3.00	Occupational Therapy	159,551						3.00	
4.00	Speech Pathology	40,965						4.00	
5.00	Medical Social Services	0						5.00	
6.00	Home Health Aide	139,520						6.00	
7.00	Total (sum of lines 1-6)	1,871,797						7.00	
Cost Center Description									
		12.00							
<b>Limitation Cost Computation</b>									
8.00	Skilled Nursing Care							8.00	
9.00	Physical Therapy							9.00	
10.00	Occupational Therapy							10.00	
11.00	Speech Pathology							11.00	
12.00	Medical Social Services							12.00	
13.00	Home Health Aide							13.00	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0034 HHA CCN: 15-7313	Period: From 07/01/2020 To 06/30/2021	Worksheet H-3 Part II Date/Time Prepared: 11/23/2021 10:33 am PPS
Title XVIII			Home Health Agency I	

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>						
1.00	Physical Therapy	66.00	0.266127	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.184258	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology	68.00	0.402176	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.303267	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.180231	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034 HHA CCN: 15-7313	Period: From 07/01/2020 To 06/30/2021	Worksheet H-4 Part I-11 Date/Time Prepared: 11/23/2021 10:33 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	7,856	0
			Part A Services	Part B Services
			1.00	2.00
<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>				
10.00	Total reasonable cost (see instructions)		0	-7,856
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	1,553,635
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	425,901
13.00	Total PPS Reimbursement - LUPA Episodes		0	29,073
14.00	Total PPS Reimbursement - PEP Episodes		0	3,516
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	127,637
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	46
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	2,131,952
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	2,131,952
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	2,131,952
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	2,131,952
30.00	OTHER ADJUSTMENT		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	2,131,952
31.01	Sequestration adjustment (see instructions)		0	0
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	2,131,952
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0034  
HHA CCN: 15-7313

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

Worksheet H-5  
Date/Time Prepared:  
11/23/2021 10:33 am  
PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		2,131,952	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		2,131,952	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		2,131,952	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00



CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Prepared: 11/23/2021 10:33 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		2,802,465	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		22,334	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		113.66	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		3.43	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		15.99	8.00
9.00	Sum of lines 7 and 8		19.42	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.01	10.00
11.00	Disproportionate share adjustment (see instructions)		112,379	11.00
12.00	Total prospective capital payments (see instructions)		2,937,178	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00