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: 15-0157	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/22/2021 12:34 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/22/2021 Time: 12:34 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ASCENSION ST. VINCENT CARMEL (15-0157) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

VP OF FINANCE
Title

11/22/2021 12:34:40 PM
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	228,479	57,541	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	228,479	57,541	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0157	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/22/2021 12:34 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 13500 NORTH MERIDIAN STREET	PO Box:			1.00
2.00	City: CARMEL	State: IN	Zip Code: 46033	County: HAMILTON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ASCENSION ST. VINCENT CARMEL	150157	26900	1	01/14/2004	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2021 12:34 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	630	28	1	3	2,954	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0157	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/22/2021 12:34 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2021 12:34 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0157	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/22/2021 12:34 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	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)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0157	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/22/2021 12:34 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	880,138	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0157	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/22/2021 12:34 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 250 WEST 96TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46260	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part II Date/Time Prepared: 11/22/2021 12:34 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	09/20/2021	Y	09/20/2021	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part II Date/Time Prepared: 11/22/2021 12:34 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JOHN	KUHN	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3236	JOHN.KUHN@STVINCENT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0157	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/22/2021 12:34 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I Date/Time Prepared: 11/22/2021 12:34 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	128	46,720	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)		128	46,720	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,650	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	NEONATAL INTENSIVE CARE UNIT	35.00	15	5,475	0.00	0	12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		153	55,845	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		153				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: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2021 12:34 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,281	153	14,350			1.00
2.00	HMO and other (see instructions)	2,611	2,958				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,281	153	14,350			7.00
8.00	INTENSIVE CARE UNIT	1,455	73	1,920			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	NEONATAL INTENSIVE CARE UNIT	0	376	1,910			12.00
13.00	NURSERY		56	2,822			13.00
14.00	Total (see instructions)	4,736	658	21,002	0.00	449.83	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	449.83	27.00
28.00	Observation Bed Days		0	2,096			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			853			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	992			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: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2021 12:34 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,102	38	5,396	1.00
2.00	HMO and other (see instructions)			509	894		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,102	38	5,396	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part II | Date/Time Prepared: 11/22/2021 12:34 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	35,827,775	-22,352	35,805,423	935,663.88	38.27	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		25,063	0	25,063	199.20	125.82	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		1,250	0	1,250	9.45	132.28	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		107,248	0	107,248	2,080.00	51.56	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		381,869	0	381,869	5,216.16	73.21	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		525,535	21,319	546,854	18,296.47	29.89	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		594,506	0	594,506	7,351.18	80.87	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		940,226	0	940,226	13,630.07	68.98	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		8,755,800	0	8,755,800	171,707.55	50.99	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		9,133,598	-22,354	9,111,244			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		136,071	0	136,071			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		6,489	0	6,489			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		324	0	324			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		2,943,380	0	2,943,380			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part II Date/Time Prepared: 11/22/2021 12:34 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	1,322,659	-1,322,659	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,553,507	342,524	1,896,031	24,658.35	76.89	27.00
28.00	Administrative & General under contract (see inst.)		760,817	0	760,817	5,624.52	135.27	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,400,014	0	1,400,014	55,502.48	25.22	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		657,399	0	657,399	23,042.74	28.53	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,675,697	54,502	1,730,199	41,659.42	41.53	38.00
39.00	Central Services and Supply	14.00	440,464	13,215	453,679	22,981.07	19.74	39.00
40.00	Pharmacy	15.00	1,915,746	49,923	1,965,669	41,798.45	47.03	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	41,160	1,073	42,233	1,368.15	30.87	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part III Date/Time Prepared: 11/22/2021 12:34 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		38,155,638	-22,352	38,133,286	1,012,528.01	37.66	1.00
2.00	Excluded area salaries (see instructions)		525,535	21,319	546,854	18,296.47	29.89	2.00
3.00	Subtotal salaries (line 1 minus line 2)		37,630,103	-43,671	37,586,432	994,231.54	37.80	3.00
4.00	Subtotal other wages & related costs (see inst.)		10,290,532	0	10,290,532	192,688.80	53.40	4.00
5.00	Subtotal wage-related costs (see inst.)		12,083,467	-22,354	12,061,113	0.00	32.09	5.00
6.00	Total (sum of lines 3 thru 5)		60,004,102	-66,025	59,938,077	1,186,920.34	50.50	6.00
7.00	Total overhead cost (see instructions)		9,767,463	-861,422	8,906,041	216,635.18	41.11	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part IV | Date/Time Prepared: 11/22/2021 12:34 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,378,209	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	235,318	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,415,258	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,116,883	9.00
10.00	Dental, Hearing and Vision Plan	122,046	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	14,497	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)	245,050	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	24,498	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,642,051	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	26,199	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	48,720	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	7,753	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,276,482	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part V Date/Time Prepared: 11/22/2021 12:34 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	594,506	9,276,482	1.00
2.00	Hospital	594,506	9,276,482	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-10 | Date/Time Prepared: 11/22/2021 12:34 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.163937	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,897,437	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	94,856,227	6.00
7.00	Medicaid cost (line 1 times line 6)	15,550,445	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	9,653,008	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	9,653,008	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)	7,435,095	1,064,656	8,499,751	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,218,887	1,064,656	2,283,543	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)	1,218,887	1,064,656	2,283,543	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)	7,427,887	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	89,013	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	136,942	27.01
28.00	Non-Medicare bad debt expense (see instructions)	7,290,945	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,243,185	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,526,728	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	13,179,736	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A | Date/Time Prepared: 11/22/2021 12:34 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		8,344,960	8,344,960	-8,368	8,336,592	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,012,759	4,012,759	0	4,012,759	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,322,659	7,249,867	8,572,526	-1,320,191	7,252,335	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,553,507	33,302,208	34,855,715	267,967	35,123,682	5.00
7.00	00700	OPERATION OF PLANT	0	4,519,215	4,519,215	20,641	4,539,856	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	652,653	652,653	41	652,694	8.00
9.00	00900	HOUSEKEEPING	0	1,831,650	1,831,650	29,152	1,860,802	9.00
10.00	01000	DIETARY	0	1,828,737	1,828,737	-684,312	1,144,425	10.00
11.00	01100	CAFETERIA	0	12,001	12,001	685,047	697,048	11.00
13.00	01300	NURSING ADMINISTRATION	1,675,697	363,366	2,039,063	54,502	2,093,565	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	440,464	54,877	495,341	41,321	536,662	14.00
15.00	01500	PHARMACY	1,915,746	124,549	2,040,295	49,923	2,090,218	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	41,160	65,977	107,137	1,073	108,210	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,470,496	2,414,401	10,884,897	-753,874	10,131,023	30.00
31.00	03100	INTENSIVE CARE UNIT	2,010,318	655,865	2,666,183	59,608	2,725,791	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,273,493	639,049	1,912,542	33,902	1,946,444	35.00
43.00	04300	NURSERY	0	0	0	1,041,689	1,041,689	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,794,948	5,984,392	9,779,340	102,479	9,881,819	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,191,274	1,713,956	3,905,230	58,654	3,963,884	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,874,489	849,190	2,723,679	49,379	2,773,058	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	181,023	22,199	203,222	4,717	207,939	54.02
57.00	05700	CT SCAN	558,083	157,573	715,656	14,543	730,199	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	275,231	134,720	409,951	7,172	417,123	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	3,252,450	3,252,450	0	3,252,450	60.00
65.00	06500	RESPIRATORY THERAPY	872,795	204,243	1,077,038	26,712	1,103,750	65.00
66.00	06600	PHYSICAL THERAPY	562,807	67,730	630,537	15,247	645,784	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,507	1,267	6,774	144	6,918	68.00
69.00	06900	ELECTROCARDIOLOGY	117,010	34,585	151,595	3,049	154,644	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,793	1,574	10,367	229	10,596	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,364,621	5,364,621	0	5,364,621	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,437,607	6,437,607	0	6,437,607	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,993,511	4,993,511	0	4,993,511	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,893,245	7,181,904	10,075,149	75,396	10,150,545	75.00
76.00	03330	ENDOSCOPY	1,777,217	1,988,748	3,765,965	49,185	3,815,150	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,486,278	749,527	2,235,805	53,382	2,289,187	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,302,240	105,211,931	140,514,171	-21,591	140,492,580	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	125,885	367,158	493,043	3,281	496,324	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	391,624	77,487	469,111	6,240	475,351	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	0	0	12,070	12,070	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	8,026	17,866	25,892	0	25,892	194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	35,827,775	105,674,442	141,502,217	0	141,502,217	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A | Date/Time Prepared: 11/22/2021 12:34 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,448,362	6,888,230		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	4,012,759		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	50,779	7,303,114		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,255,678	26,868,004		5.00
7.00	00700	OPERATION OF PLANT	-5,189	4,534,667		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	652,694		8.00
9.00	00900	HOUSEKEEPING	0	1,860,802		9.00
10.00	01000	DIETARY	-8,789	1,135,636		10.00
11.00	01100	CAFETERIA	-285,690	411,358		11.00
13.00	01300	NURSING ADMINISTRATION	-28,828	2,064,737		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-3,750	532,912		14.00
15.00	01500	PHARMACY	-831	2,089,387		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
17.00	01700	SOCIAL SERVICE	199	108,409		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-625,728	9,505,295		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,725,791		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-30,366	1,916,078		35.00
43.00	04300	NURSERY	0	1,041,689		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-385,946	9,495,873		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,014,125	2,949,759		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-138,076	2,634,982		54.00
54.01	03480	ONCOLOGY	0	0		54.01
54.02	05402	ULTRASOUND	0	207,939		54.02
57.00	05700	CT SCAN	-26,927	703,272		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-8,696	408,427		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	3,252,450		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,103,750		65.00
66.00	06600	PHYSICAL THERAPY	0	645,784		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	6,918		68.00
69.00	06900	ELECTROCARDIOLOGY	0	154,644		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	10,596		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,364,621		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,437,607		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,993,511		73.00
75.00	07500	ASC (NON-DISTINCT PART)	-976,634	9,173,911		75.00
76.00	03330	ENDOSCOPY	37,409	3,852,559		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-21,738	2,267,449		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,176,966	127,315,614		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	496,324		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	475,351		192.00
194.00	07950	MISSION EFFECTIVENESS	0	0		194.00
194.01	07951	MARKETING	0	0		194.01
194.02	07952	JOINT VENTURES	0	0		194.02
194.04	07954	SCHOOL NURSE	0	12,070		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	25,892		194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,176,966	128,325,251		200.00

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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - NURSERY RECLASS				
1.00	NURSERY	43.00	878,809	162,880	1.00
	0		878,809	162,880	
	B - PTO ACCRUAL				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,479	0	1.00
	0		2,479	0	
	C - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	0	685,047	1.00
	0		0	685,047	
	E - PANDEMIC SALARY RECLASS				
1.00	NURSING ADMINISTRATION	13.00	4,226	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	1,737	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	19,103	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	1,409	0	4.00
5.00	OPERATING ROOM	50.00	2,542	0	5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	1,019	0	6.00
7.00	RESPIRATORY THERAPY	65.00	3,967	0	7.00
8.00	PHYSICAL THERAPY	66.00	437	0	8.00
9.00	ENDOSCOPY	76.00	2,712	0	9.00
10.00	EMERGENCY	91.00	14,650	0	10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	293	0	11.00
12.00	SCHOOL NURSE	194.04	12,070	0	12.00
	0		64,165	0	
	F - INTEREST RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,368	1.00
	0		0	8,368	
	G - NONPHYSICIAN STARP RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	17,131	0	1.00
2.00	NURSING ADMINISTRATION	13.00	43,668	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	11,478	0	3.00
4.00	PHARMACY	15.00	49,923	0	4.00
5.00	SOCIAL SERVICE	17.00	1,073	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	220,737	0	6.00
7.00	INTENSIVE CARE UNIT	31.00	52,388	0	7.00
8.00	NEONATAL INTENSIVE CARE UNIT	35.00	33,187	0	8.00
9.00	OPERATING ROOM	50.00	98,894	0	9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	57,071	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	48,848	0	11.00
12.00	ULTRASOUND	54.02	4,717	0	12.00
13.00	CT SCAN	57.00	14,543	0	13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	7,172	0	14.00
15.00	RESPIRATORY THERAPY	65.00	22,745	0	15.00
16.00	PHYSICAL THERAPY	66.00	14,666	0	16.00
17.00	SPEECH PATHOLOGY	68.00	144	0	17.00
18.00	ELECTROCARDIOLOGY	69.00	3,049	0	18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	229	0	19.00
20.00	ASC (NON-DISTINCT PART)	75.00	75,396	0	20.00
21.00	ENDOSCOPY	76.00	46,313	0	21.00
22.00	EMERGENCY	91.00	38,732	0	22.00
23.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	3,281	0	23.00
24.00	PHYSICIANS' PRIVATE OFFICES	192.00	5,675	0	24.00
	TOTALS		871,060	0	
	H - SEVERANCE RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	454,078	0	1.00
	TOTALS		454,078	0	
	I - SYSTEM PROJECT (SITTERS) RECLASS				
1.00	NURSING ADMINISTRATION	13.00	6,608	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	44,084	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	5,811	0	3.00
4.00	OPERATING ROOM	50.00	315	0	4.00
5.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,188	5.00
	TOTALS		56,818	4,188	
	J - VACCINE RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	3,891	0	1.00
2.00	NEONATAL INTENSIVE CARE UNIT	35.00	715	0	2.00
3.00	OPERATING ROOM	50.00	728	0	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	564	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	531	0	5.00
6.00	PHYSICAL THERAPY	66.00	144	0	6.00
7.00	ENDOSCOPY	76.00	160	0	7.00
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	272	0	8.00
	TOTALS		7,005	0	

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		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	K - VACCINE TO WORKERS COMP RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	697		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	3,891		2.00
3.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	715		3.00
4.00	OPERATING ROOM	50.00	0	728		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	564		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	531		6.00
7.00	PHYSICAL THERAPY	66.00	0	144		7.00
8.00	ENDOSCOPY	76.00	0	160		8.00
9.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	272		9.00
	TOTALS		0	7,702		
	L - FURLOUGH (SCK) RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	10,390		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,019		2.00
3.00	ENDOSCOPY	76.00	0	466		3.00
4.00	EMERGENCY	91.00	0	5,254		4.00
	TOTALS		0	17,129		
	M - PANDEMIC OTHER COSTS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	759		1.00
2.00	OPERATION OF PLANT	7.00	0	20,641		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	41		3.00
4.00	HOUSEKEEPING	9.00	0	29,152		4.00
5.00	DIETARY	10.00	0	735		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	28,106		6.00
	TOTALS		0	79,434		
500.00	Grand Total: Increases		2,334,414	964,748		500.00

RECLASSIFICATIONS | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-6 | Date/Time Prepared: 11/22/2021 12:34 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - NURSERY RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	878,809	162,880	0	1.00
	0		878,809	162,880		
	B - PTO ACCRUAL					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,479	0	1.00
	0		0	2,479		
	C - CAFETERIA RECLASS					
1.00	DIETARY	10.00	0	685,047	0	1.00
	0		0	685,047		
	E - PANDEMIC SALARY RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	64,165	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
	0		64,165	0		
	F - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,368	11	1.00
	0		0	8,368		
	G - NONPHYSICIAN STARP RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	871,060	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
23.00		0.00	0	0	0	23.00
24.00		0.00	0	0	0	24.00
	TOTALS		871,060	0		
	H - SEVERANCE RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	454,078	0	0	1.00
	TOTALS		454,078	0		
	I - SYSTEM PROJECT (SITTERS) RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	56,818	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	4,188	0	5.00
	TOTALS		56,818	4,188		
	J - VACCINE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	7,005	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
	TOTALS		7,005	0		

RECLASSIFICATIONS | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-6 | Date/Time Prepared: 11/22/2021 12:34 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	K - VACCINE TO WORKERS COMP RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	697	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	3,891	0	0		2.00
3.00	NEONATAL INTENSIVE CARE UNIT	35.00	715	0	0		3.00
4.00	OPERATING ROOM	50.00	728	0	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	564	0	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	531	0	0		6.00
7.00	PHYSICAL THERAPY	66.00	144	0	0		7.00
8.00	ENDOSCOPY	76.00	160	0	0		8.00
9.00	PHYSICIANS' PRIVATE OFFICES	192.00	272	0	0		9.00
	TOTALS		7,702	0			
	L - FURLOUGH (SCK) RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	10,390	0	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,019	0	0		2.00
3.00	ENDOSCOPY	76.00	466	0	0		3.00
4.00	EMERGENCY	91.00	5,254	0	0		4.00
	TOTALS		17,129	0			
	M - PANDEMIC OTHER COSTS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	79,434	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
	TOTALS		0	79,434			
500.00	Grand Total: Decreases		2,356,766	942,396			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part I | Date/Time Prepared: 11/22/2021 12:34 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	15,676,014	0	0	0	0	1.00
2.00	Land Improvements	2,618,833	892,653	0	892,653	0	2.00
3.00	Buildings and Fixtures	84,037,828	3,504,478	0	3,504,478	0	3.00
4.00	Building Improvements	3,288,035	0	0	0	0	4.00
5.00	Fixed Equipment	17,837,452	728,704	0	728,704	0	5.00
6.00	Movable Equipment	49,850,732	4,288,136	0	4,288,136	11,865	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	173,308,894	9,413,971	0	9,413,971	11,865	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	173,308,894	9,413,971	0	9,413,971	11,865	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	15,676,014	0	1.00
2.00	Land Improvements	3,511,486	0	2.00
3.00	Buildings and Fixtures	87,542,306	0	3.00
4.00	Building Improvements	3,288,035	0	4.00
5.00	Fixed Equipment	18,566,156	0	5.00
6.00	Movable Equipment	54,127,003	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	182,711,000	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	182,711,000	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part II | Date/Time Prepared: 11/22/2021 12:34 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,592,919	3,788,470	669,697	0	293,874	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,015,503	990,592	0	0	6,664	2.00
3.00	Total (sum of lines 1-2)	6,608,422	4,779,062	669,697	0	300,538	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	8,344,960	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,012,759	2.00
3.00	Total (sum of lines 1-2)	0	12,357,719	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part III Date/Time Prepared: 11/22/2021 12:34 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	128,583,996	0	128,583,996	0.703756	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	54,127,003	0	54,127,003	0.296244	0	2.00
3.00	Total (sum of lines 1-2)	182,710,999	0	182,710,999	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,592,919	3,788,470	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,015,503	990,592	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,608,422	4,779,062	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-8,369	0	293,874	-778,664	6,888,230	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	6,664	0	4,012,759	2.00
3.00	Total (sum of lines 1-2)	-8,369	0	300,538	-778,664	10,900,989	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8 | Date/Time Prepared: 11/22/2021 12:34 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-661,330	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-48,972	ADMINISTRATIVE & GENERAL	5.00	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)	A	-5,189	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,992,923			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	4,164,844			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-285,690	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-831	PHARMACY	15.00	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	B	-6,921	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	DONATIONS MADE	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8 | Date/Time Prepared: 11/22/2021 12:34 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	BILLING ARRANGEMENTS	B	-606,380	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.02
33.03	MEALS ON WHEELS	B	-1,868	DIETARY	10.00	0	33.03
34.00	ADMINISTRATIVE FEES	B	-500	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	CONSOLIDATING ENTRY	B	-1,110,560	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	PATIENT INTEREST INCOME - A&G	B	-12,292	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	PATIENT INTEREST INCOME - ENDO	B	-48	ENDOSCOPY	76.00	0	37.00
37.01	PATIENT INTEREST INCOME - ASC	B	-10,089	ASC (NON-DISTINCT PART)	75.00	0	37.01
37.02	PATIENT INTEREST INCOME - ROUTINE	B	-1	ADULTS & PEDIATRICS	30.00	0	37.02
37.03	PATIENT INTEREST INCOME - NEONATOLOG	B	-13	NEONATAL INTENSIVE CARE UNIT	35.00	0	37.03
38.00	OTHER MISC REVENUE - NURS ADMIN	B	-400	NURSING ADMINISTRATION	13.00	0	38.00
38.01	OTHER MISC REVENUE - ROUTINE	B	-543	ADULTS & PEDIATRICS	30.00	0	38.01
39.00	OTHER MISC REVENUE - RADIOLOGY	B	-650	RADIOLOGY-DIAGNOSTIC	54.00	0	39.00
40.00	OTHER MISC REVENUE - E.D.	B	-535	EMERGENCY	91.00	0	40.00
41.00	OTHER MISC REVENUE - ASC	B	-966,545	ASC (NON-DISTINCT PART)	75.00	0	41.00
42.00	OTHER MISC REVENUE - ENDO	B	43,777	ENDOSCOPY	76.00	0	42.00
42.01	LATE PENALTY FEES - BARIATRIC SVCS	B	-24	ADULTS & PEDIATRICS	30.00	0	42.01
43.00	LATE PENALTY FEES - LEASED SPACE	B	-286	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.00
44.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.01
45.00	RENTAL OF HOSPITAL SPACE	B	-778,664	CAP REL COSTS-BLDG & FIXT	1.00	14	45.00
46.00	ONSITE CLINICS OTHER REVENUE	B	-129,210	ADULTS & PEDIATRICS	30.00	0	46.00
47.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	47.00
49.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.00
49.01	ENTERTAINMENT - A&G	A	-4,422	ADMINISTRATIVE & GENERAL	5.00	0	49.01
49.02	ENTERTAINMENT - NURS ADMIN	A	-36	NURSING ADMINISTRATION	13.00	0	49.02
49.03	ENTERTAINMENT - ROUTINE	A	-452	ADULTS & PEDIATRICS	30.00	0	49.03
49.04	ENTERTAINMENT - OR	A	-2,296	OPERATING ROOM	50.00	0	49.04
49.05	ENTERTAINMENT - RADIOLOGY	A	-482	RADIOLOGY-DIAGNOSTIC	54.00	0	49.05
49.06	ENTERTAINMENT - NEONATOLOGY	A	-353	NEONATAL INTENSIVE CARE UNIT	35.00	0	49.06
49.07	ADVERTISING - ENDO	A	-4,320	ENDOSCOPY	76.00	0	49.07
49.08	ADVERTISING - ASC	A	-21,203	EMERGENCY	91.00	0	49.08
49.09	MARKETING - CS&S	A	-3,750	CENTRAL SERVICES & SUPPLY	14.00	0	49.09
49.10	MARKETING - ROUTINE	A	-7,781	ADULTS & PEDIATRICS	30.00	0	49.10
49.11	MARKETING - L&D	A	-170	DELIVERY ROOM & LABOR ROOM	52.00	0	49.11
49.12	CHARITABLE EXPENSE - CASE MGMT	A	-28,392	NURSING ADMINISTRATION	13.00	0	49.12
49.13	CHARITABLE EXPENSE - SOCIAL SVCS	A	199	SOCIAL SERVICE	17.00	0	49.13
49.14	CHARITABLE EXPENSE - ENDO	A	-2,000	ENDOSCOPY	76.00	0	49.14
49.15	PHYSICIAN FUNDS EXPENSE	A	-2,146,981	ADMINISTRATIVE & GENERAL	5.00	0	49.15
49.16	MIDLEVEL PROVIDER - A&G	A	-431	ADMINISTRATIVE & GENERAL	5.00	0	49.16
49.17	MIDLEVEL PROVIDER - ROUTINE	A	-107,257	ADULTS & PEDIATRICS	30.00	0	49.17
49.22	LOBBYING	A	-1,925	ADMINISTRATIVE & GENERAL	5.00	0	49.22
49.23	PROVIDER ASSESSMENT OFFSET	B	-8,433,071	ADMINISTRATIVE & GENERAL	5.00	0	49.23
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,176,966				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: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-1 | Date/Time Prepared: 11/22/2021 12:34 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	5,297,376	5,246,597	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	2,239,340	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST - CAP	39,864	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST - A&G	740	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	23,914,225	22,080,104	3.02
3.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	95,467	95,467	3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACKS	669,388	669,388	3.04
3.05	13.00	NURSING ADMINISTRATION	SVH CHARGEBACKS	-4,805	-4,805	3.05
3.06	15.00	PHARMACY	SVH CHARGEBACKS	36,000	36,000	3.06
3.07	30.00	ADULTS & PEDIATRICS	SVH CHARGEBACKS	1,318	1,318	3.07
3.08	31.00	INTENSIVE CARE UNIT	SVH CHARGEBACKS	230,000	230,000	3.08
3.09	35.00	NEONATAL INTENSIVE CARE UNIT	SVH CHARGEBACKS	402,836	402,836	3.09
3.10	52.00	DELIVERY ROOM & LABOR ROOM	SVH CHARGEBACKS	242,985	242,985	3.10
3.11	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACKS	97,954	97,954	3.11
3.12	66.00	PHYSICAL THERAPY	SVH CHARGEBACKS	41,268	41,268	3.12
4.00	194.06	SPORTS MEDICINE & OB PHYS	SVH CHARGEBACKS	25,000	25,000	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXP - CAPITAL	661,330	669,698	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXP - A&G	8,368	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			33,998,654	29,833,810	5.00

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

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

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

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

6.00	G	ST. VINCENT HEA	100.00	ST. VINCENT HEA	100.00	6.00
7.00	G	ASCENSION HEALT	100.00	ASCENSION HEALT	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0157	Period: From 07/01/2020 To 06/30/2021	Worksheet A-8-1 Date/Time Prepared: 11/22/2021 12:34 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	50,779	0		1.00
2.00	2,239,340	0		2.00
3.00	39,864	0		3.00
3.01	740	0		3.01
3.02	1,834,121	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
4.00	0	0		4.00
4.01	-8,368	11		4.01
4.02	8,368	0		4.02
5.00	4,164,844			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	HOME OFFICE		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: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-2 | Date/Time Prepared: 11/22/2021 12:34 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	155,969	0	155,969	211,500	1,413	1.00
2.00	30.00	ADULTS & PEDIATRICS	380,460	380,460	0	0	0	2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	30,000	30,000	0	0	0	3.00
4.00	50.00	OPERATING ROOM	1,333,637	383,650	949,987	246,400	23,896	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	1,014,870	1,013,620	1,250	211,500	9	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	157,990	129,822	28,168	271,900	161	6.00
7.00	57.00	CT SCAN	26,927	26,927	0	0	0	7.00
8.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	8,696	8,696	0	0	0	8.00
9.00	91.00	EMERGENCY	168,124	0	168,124	211,500	2,882	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,276,673	1,973,175	1,303,498		28,361	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	143,678	7,184	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	2,830,757	141,538	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	915	46	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	21,046	1,052	0	0	0	6.00
7.00	57.00	CT SCAN	0	0	0	0	0	7.00
8.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	293,050	14,653	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,289,446	164,473	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	143,678	12,291	12,291		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	380,460		2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	0	0	30,000		3.00
4.00	50.00	OPERATING ROOM	0	2,830,757	0	383,650		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	915	335	1,013,955		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	21,046	7,122	136,944		6.00
7.00	57.00	CT SCAN	0	0	0	26,927		7.00
8.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	8,696		8.00
9.00	91.00	EMERGENCY	0	293,050	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	3,289,446	19,748	1,992,923		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I Date/Time Prepared: 11/22/2021 12:34 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	6,888,230	6,888,230				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,012,759		4,012,759			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,303,114	90,648	0	7,393,762		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,868,004	437,648	378,049	391,527	28,075,228	5.00
7.00	00700	OPERATION OF PLANT	4,534,667	804,548	36,167	0	5,375,382	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	652,694	41,814	0	0	694,508	8.00
9.00	00900	HOUSEKEEPING	1,860,802	117,335	3,207	0	1,981,344	9.00
10.00	01000	DIETARY	1,135,636	151,296	3,026	0	1,289,958	10.00
11.00	01100	CAFETERIA	411,358	176,523	2,213	0	590,094	11.00
13.00	01300	NURSING ADMINISTRATION	2,064,737	3,174	130,379	357,283	2,555,573	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	532,912	153,450	46,522	93,684	826,568	14.00
15.00	01500	PHARMACY	2,089,387	120,763	147,758	405,907	2,763,815	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,019	0	0	7,019	16.00
17.00	01700	SOCIAL SERVICE	108,409	16,656	0	8,721	133,786	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,505,295	1,558,200	206,243	1,624,165	12,893,903	30.00
31.00	03100	INTENSIVE CARE UNIT	2,725,791	160,052	124,218	427,436	3,437,497	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,916,078	159,311	39,543	269,827	2,384,759	35.00
43.00	04300	NURSERY	1,041,689	286,978	15,380	181,472	1,525,519	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,495,873	614,171	1,285,242	804,661	12,199,947	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,949,759	326,244	73,200	464,279	3,813,482	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,634,982	330,182	285,439	397,165	3,647,768	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	207,939	7,992	88,160	38,355	342,446	54.02
57.00	05700	CT SCAN	703,272	89,119	185,063	118,246	1,095,700	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	408,427	184,585	301,687	58,316	953,015	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,252,450	111,821	0	0	3,364,271	60.00
65.00	06500	RESPIRATORY THERAPY	1,103,750	55,088	100,851	185,746	1,445,435	65.00
66.00	06600	PHYSICAL THERAPY	645,784	46,841	0	119,337	811,962	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,918	510	0	1,167	8,595	68.00
69.00	06900	ELECTROCARDIOLOGY	154,644	5,884	15,144	24,792	200,464	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,596	394	9,348	1,863	22,201	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,364,621	0	0	0	5,364,621	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,437,607	0	0	0	6,437,607	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,993,511	0	0	0	4,993,511	73.00
75.00	07500	ASC (NON-DISTINCT PART)	9,173,911	293,673	283,271	613,018	10,363,873	75.00
76.00	03330	ENDOSCOPY	3,852,559	121,875	208,924	377,019	4,560,377	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,267,449	315,402	41,618	316,852	2,941,321	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	127,315,614	6,789,196	4,010,652	7,280,838	127,101,549	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	496,324	38,316	0	26,673	561,313	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	475,351	0	668	82,102	558,121	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	487	0	487	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	12,070	20,502	0	2,492	35,064	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	25,892	40,216	952	1,657	68,717	194.06
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	128,325,251	6,888,230	4,012,759	7,393,762	128,325,251	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I | Date/Time Prepared: 11/22/2021 12:34 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,075,228					5.00
7.00	00700	OPERATION OF PLANT	1,505,386	6,880,768				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	194,498	51,790	940,796			8.00
9.00	00900	HOUSEKEEPING	554,879	145,328	0	2,681,551		9.00
10.00	01000	DIETARY	361,255	187,391	0	75,183	1,913,787	10.00
11.00	01100	CAFETERIA	165,257	218,637	0	87,720	0	11.00
13.00	01300	NURSING ADMINISTRATION	715,693	3,931	0	1,577	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	231,482	190,060	24,041	76,254	0	14.00
15.00	01500	PHARMACY	774,012	149,574	0	60,011	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,966	8,694	0	3,488	0	16.00
17.00	01700	SOCIAL SERVICE	37,467	20,630	0	8,277	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,610,971	1,929,949	288,185	774,316	1,657,691	30.00
31.00	03100	INTENSIVE CARE UNIT	962,678	198,237	30,573	79,535	144,313	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	667,857	197,319	0	79,166	0	35.00
43.00	04300	NURSERY	427,225	355,444	79,453	142,608	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,416,620	760,698	191,363	305,200	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,067,973	404,078	28,217	162,120	111,783	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,021,565	408,955	62,781	164,077	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	95,903	9,899	3,547	3,972	0	54.02
57.00	05700	CT SCAN	306,853	110,380	12,489	44,286	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	266,894	228,622	20,340	91,726	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	942,171	138,499	0	55,567	0	60.00
65.00	06500	RESPIRATORY THERAPY	404,797	68,231	477	27,375	0	65.00
66.00	06600	PHYSICAL THERAPY	227,392	58,016	1,234	23,277	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,407	631	13	253	0	68.00
69.00	06900	ELECTROCARDIOLOGY	56,140	7,288	66	2,924	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,217	488	5	196	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,502,373	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,802,865	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,398,443	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,902,423	363,736	38,231	145,935	0	75.00
76.00	03330	ENDOSCOPY	1,277,143	150,952	55,422	60,563	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	823,723	390,650	100,064	156,733	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,732,528	6,758,107	936,501	2,632,339	1,913,787	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	157,197	47,458	0	19,040	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	156,303	0	0	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	136	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	9,820	25,393	0	10,188	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	19,244	49,810	4,295	19,984	0	194.06
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)	28,075,228	6,880,768	940,796	2,681,551	1,913,787	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I | Date/Time Prepared: 11/22/2021 12:34 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,061,708					11.00
13.00	01300	NURSING ADMINISTRATION	48,561	3,325,335				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26,789	2,788	1,377,982			14.00
15.00	01500	PHARMACY	48,724	5,180	6,871	3,808,187		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	21,167	16.00
17.00	01700	SOCIAL SERVICE	1,595	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	248,108	1,280,452	30,590	0	1,992	30.00
31.00	03100	INTENSIVE CARE UNIT	46,842	326,811	12,092	0	489	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	48,070	244,002	4,592	0	533	35.00
43.00	04300	NURSERY	28,934	190,519	280	0	257	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	125,290	423,212	270,832	0	6,627	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	67,300	361,752	14,032	0	1,356	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,668	45,649	24,568	0	880	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	14,122	0	70	0	119	54.02
57.00	05700	CT SCAN	17,165	36	5,028	0	310	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,461	13	2,631	0	109	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	35	0	1,414	60.00
65.00	06500	RESPIRATORY THERAPY	26,490	1,510	8,974	0	289	65.00
66.00	06600	PHYSICAL THERAPY	16,603	0	1,000	0	116	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	175	0	11	0	4	68.00
69.00	06900	ELECTROCARDIOLOGY	2,329	31	1,567	0	137	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	145	0	56	0	38	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	328,340	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	398,000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,808,187	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	104,821	0	198,263	0	3,076	75.00
76.00	03330	ENDOSCOPY	62,382	116,062	55,370	0	1,916	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	40,275	258,932	12,752	0	1,505	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,040,849	3,256,949	1,375,954	3,808,187	21,167	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,887	0	2,028	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,181	9,972	0	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	58,414	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	4,791	0	0	0	0	194.06
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)	1,061,708	3,325,335	1,377,982	3,808,187	21,167	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I Date/Time Prepared: 11/22/2021 12:34 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	201,755					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,285	22,761,442	0	22,761,442		30.00
31.00	03100	INTENSIVE CARE UNIT	20,704	5,259,771	0	5,259,771		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	33,611	3,659,909	0	3,659,909		35.00
43.00	04300	NURSERY	0	2,750,239	0	2,750,239		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,964	17,703,753	0	17,703,753		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,524	6,057,617	0	6,057,617		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,433,911	0	5,433,911		54.00
54.01	03480	ONCOLOGY	0	0	0	0		54.01
54.02	05402	ULTRASOUND	0	470,078	0	470,078		54.02
57.00	05700	CT SCAN	0	1,592,247	0	1,592,247		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,571,811	0	1,571,811		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	4,501,957	0	4,501,957		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,983,578	0	1,983,578		65.00
66.00	06600	PHYSICAL THERAPY	0	1,139,600	0	1,139,600		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	12,089	0	12,089		68.00
69.00	06900	ELECTROCARDIOLOGY	0	270,946	0	270,946		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	29,346	0	29,346		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,195,334	0	7,195,334		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,638,472	0	8,638,472		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,200,141	0	10,200,141		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	14,120,358	0	14,120,358		75.00
76.00	03330	ENDOSCOPY	10,570	6,350,757	0	6,350,757		76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	51,513	4,777,468	0	4,777,468		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	191,171	126,480,824	0	126,480,824		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	793,923	0	793,923		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,584	744,161	0	744,161		192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0		194.00
194.01	07951	MARKETING	0	623	0	623		194.01
194.02	07952	JOINT VENTURES	0	0	0	0		194.02
194.04	07954	SCHOOL NURSE	0	138,879	0	138,879		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	166,841	0	166,841		194.06
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	201,755	128,325,251	0	128,325,251		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II Date/Time Prepared: 11/22/2021 12:34 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	90,648	0	90,648	90,648	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,239,340	437,648	378,049	3,055,037	4,801	5.00
7.00	00700	OPERATION OF PLANT	0	804,548	36,167	840,715	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	41,814	0	41,814	0	8.00
9.00	00900	HOUSEKEEPING	0	117,335	3,207	120,542	0	9.00
10.00	01000	DIETARY	0	151,296	3,026	154,322	0	10.00
11.00	01100	CAFETERIA	0	176,523	2,213	178,736	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,174	130,379	133,553	4,381	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	153,450	46,522	199,972	1,149	14.00
15.00	01500	PHARMACY	0	120,763	147,758	268,521	4,977	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,019	0	7,019	0	16.00
17.00	01700	SOCIAL SERVICE	0	16,656	0	16,656	107	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,558,200	206,243	1,764,443	19,902	30.00
31.00	03100	INTENSIVE CARE UNIT	0	160,052	124,218	284,270	5,241	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	159,311	39,543	198,854	3,309	35.00
43.00	04300	NURSERY	0	286,978	15,380	302,358	2,225	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	614,171	1,285,242	1,899,413	9,866	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	326,244	73,200	399,444	5,693	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	330,182	285,439	615,621	4,870	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	7,992	88,160	96,152	470	54.02
57.00	05700	CT SCAN	0	89,119	185,063	274,182	1,450	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	184,585	301,687	486,272	715	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	111,821	0	111,821	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	55,088	100,851	155,939	2,278	65.00
66.00	06600	PHYSICAL THERAPY	0	46,841	0	46,841	1,463	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	510	0	510	14	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,884	15,144	21,028	304	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	394	9,348	9,742	23	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	293,673	283,271	576,944	7,517	75.00
76.00	03330	ENDOSCOPY	0	121,875	208,924	330,799	4,623	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	315,402	41,618	357,020	3,885	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,239,340	6,789,196	4,010,652	13,039,188	89,263	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,316	0	38,316	327	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	668	668	1,007	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	487	487	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	20,502	0	20,502	31	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	40,216	952	41,168	20	194.06
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,239,340	6,888,230	4,012,759	13,140,329	90,648	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II | Date/Time Prepared: 11/22/2021 12:34 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,059,838					5.00
7.00	00700	OPERATION OF PLANT	164,067	1,004,782				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,198	7,563	70,575			8.00
9.00	00900	HOUSEKEEPING	60,475	21,222	0	202,239		9.00
10.00	01000	DIETARY	39,372	27,364	0	5,670	226,728	10.00
11.00	01100	CAFETERIA	18,011	31,927	0	6,616	0	11.00
13.00	01300	NURSING ADMINISTRATION	78,001	574	0	119	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,229	27,754	1,803	5,751	0	14.00
15.00	01500	PHARMACY	84,357	21,842	0	4,526	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	214	1,270	0	263	0	16.00
17.00	01700	SOCIAL SERVICE	4,083	3,013	0	624	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	393,554	281,824	21,619	58,396	196,388	30.00
31.00	03100	INTENSIVE CARE UNIT	104,919	28,948	2,293	5,998	17,097	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	72,788	28,814	0	5,971	0	35.00
43.00	04300	NURSERY	46,562	51,905	5,960	10,755	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	372,367	111,083	14,355	23,018	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	116,395	59,006	2,117	12,227	13,243	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	111,337	59,719	4,710	12,374	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	10,452	1,446	266	300	0	54.02
57.00	05700	CT SCAN	33,443	16,119	937	3,340	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	29,088	33,385	1,526	6,918	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	102,684	20,225	0	4,191	0	60.00
65.00	06500	RESPIRATORY THERAPY	44,118	9,964	36	2,065	0	65.00
66.00	06600	PHYSICAL THERAPY	24,783	8,472	93	1,756	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	262	92	1	19	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,119	1,064	5	221	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	678	71	0	15	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	163,739	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	196,489	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	152,412	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	316,326	53,115	2,868	11,006	0	75.00
76.00	03330	ENDOSCOPY	139,192	22,043	4,158	4,568	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	89,775	57,046	7,506	11,821	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,022,489	986,870	70,253	198,528	226,728	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,132	6,930	0	1,436	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,035	0	0	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	15	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	1,070	3,708	0	768	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	2,097	7,274	322	1,507	0	194.06
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)	3,059,838	1,004,782	70,575	202,239	226,728	202.00

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		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	235,290					11.00
13.00	01300	NURSING ADMINISTRATION	10,762	227,390				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,937	191	267,786			14.00
15.00	01500	PHARMACY	10,798	354	1,335	396,710		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	8,766	16.00
17.00	01700	SOCIAL SERVICE	353	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,984	87,559	5,944	0	809	30.00
31.00	03100	INTENSIVE CARE UNIT	10,381	22,348	2,350	0	199	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	10,653	16,685	892	0	217	35.00
43.00	04300	NURSERY	6,412	13,028	54	0	105	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,766	28,940	52,630	0	2,859	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,915	24,737	2,727	0	551	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,780	3,122	4,774	0	357	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	3,130	0	14	0	48	54.02
57.00	05700	CT SCAN	3,804	2	977	0	126	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,875	1	511	0	44	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	7	0	575	60.00
65.00	06500	RESPIRATORY THERAPY	5,871	103	1,744	0	117	65.00
66.00	06600	PHYSICAL THERAPY	3,679	0	194	0	47	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	39	0	2	0	2	68.00
69.00	06900	ELECTROCARDIOLOGY	516	2	304	0	56	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	32	0	11	0	16	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	63,805	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	77,351	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	396,710	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	23,230	0	38,528	0	1,249	75.00
76.00	03330	ENDOSCOPY	13,825	7,936	10,760	0	778	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,925	17,706	2,478	0	611	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	230,667	222,714	267,392	396,710	8,766	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,526	0	394	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,035	682	0	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	3,994	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	1,062	0	0	0	0	194.06
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)	235,290	227,390	267,786	396,710	8,766	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II Date/Time Prepared: 11/22/2021 12:34 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	24,836					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,575	2,890,997	0	2,890,997		30.00
31.00	03100	INTENSIVE CARE UNIT	2,549	486,593	0	486,593		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	4,138	342,321	0	342,321		35.00
43.00	04300	NURSERY	0	439,364	0	439,364		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	488	2,542,785	0	2,542,785		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,142	654,197	0	654,197		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	829,664	0	829,664		54.00
54.01	03480	ONCOLOGY	0	0	0	0		54.01
54.02	05402	ULTRASOUND	0	112,278	0	112,278		54.02
57.00	05700	CT SCAN	0	334,380	0	334,380		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	560,335	0	560,335		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	239,503	0	239,503		60.00
65.00	06500	RESPIRATORY THERAPY	0	222,235	0	222,235		65.00
66.00	06600	PHYSICAL THERAPY	0	87,328	0	87,328		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	941	0	941		68.00
69.00	06900	ELECTROCARDIOLOGY	0	29,619	0	29,619		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	10,588	0	10,588		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	227,544	0	227,544		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	273,840	0	273,840		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	549,122	0	549,122		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	1,030,783	0	1,030,783		75.00
76.00	03330	ENDOSCOPY	1,301	539,983	0	539,983		76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,340	563,113	0	563,113		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,533	12,967,513	0	12,967,513		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	66,061	0	66,061		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,303	22,730	0	22,730		192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0		194.00
194.01	07951	MARKETING	0	502	0	502		194.01
194.02	07952	JOINT VENTURES	0	0	0	0		194.02
194.04	07954	SCHOOL NURSE	0	30,073	0	30,073		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	53,450	0	53,450		194.06
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	24,836	13,140,329	0	13,140,329		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/22/2021 12:34 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	297,345					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,012,759				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,913	0	35,805,423			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,892	378,049	1,896,031	-28,075,228	100,250,023	5.00
7.00	00700	OPERATION OF PLANT	34,730	36,167	0	0	5,375,382	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,805	0	0	0	694,508	8.00
9.00	00900	HOUSEKEEPING	5,065	3,207	0	0	1,981,344	9.00
10.00	01000	DIETARY	6,531	3,026	0	0	1,289,958	10.00
11.00	01100	CAFETERIA	7,620	2,213	0	0	590,094	11.00
13.00	01300	NURSING ADMINISTRATION	137	130,379	1,730,199	0	2,555,573	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,624	46,522	453,679	0	826,568	14.00
15.00	01500	PHARMACY	5,213	147,758	1,965,669	0	2,763,815	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	303	0	0	0	7,019	16.00
17.00	01700	SOCIAL SERVICE	719	0	42,233	0	133,786	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,263	206,243	7,865,221	0	12,893,903	30.00
31.00	03100	INTENSIVE CARE UNIT	6,909	124,218	2,069,926	0	3,437,497	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,877	39,543	1,306,680	0	2,384,759	35.00
43.00	04300	NURSERY	12,388	15,380	878,809	0	1,525,519	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,512	1,285,242	3,896,699	0	12,199,947	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,083	73,200	2,248,345	0	3,813,482	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,253	285,439	1,923,337	0	3,647,768	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	345	88,160	185,740	0	342,446	54.02
57.00	05700	CT SCAN	3,847	185,063	572,626	0	1,095,700	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,968	301,687	282,403	0	953,015	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,827	0	0	0	3,364,271	60.00
65.00	06500	RESPIRATORY THERAPY	2,378	100,851	899,507	0	1,445,435	65.00
66.00	06600	PHYSICAL THERAPY	2,022	0	577,910	0	811,962	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	22	0	5,651	0	8,595	68.00
69.00	06900	ELECTROCARDIOLOGY	254	15,144	120,059	0	200,464	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17	9,348	9,022	0	22,201	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5,364,621	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,437,607	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,993,511	73.00
75.00	07500	ASC (NON-DISTINCT PART)	12,677	283,271	2,968,641	0	10,363,873	75.00
76.00	03330	ENDOSCOPY	5,261	208,924	1,825,776	0	4,560,377	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,615	41,618	1,534,406	0	2,941,321	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	293,070	4,010,652	35,258,569	-28,075,228	99,026,321	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,654	0	129,166	0	561,313	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	668	397,592	0	558,121	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	487	0	0	487	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	885	0	12,070	0	35,064	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	1,736	952	8,026	0	68,717	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,888,230	4,012,759	7,393,762		28,075,228	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.165784	1.000000	0.206498		0.280052	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			90,648		3,059,838	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002532		0.030522	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: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/22/2021 12:34 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	239,810					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,805	567,934				8.00
9.00	00900	HOUSEKEEPING	5,065	0	232,940			9.00
10.00	01000	DIETARY	6,531	0	6,531	51,242		10.00
11.00	01100	CAFETERIA	7,620	0	7,620	0	910,798	11.00
13.00	01300	NURSING ADMINISTRATION	137	0	137	0	41,659	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,624	14,513	6,624	0	22,981	14.00
15.00	01500	PHARMACY	5,213	0	5,213	0	41,798	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	303	0	303	0	0	16.00
17.00	01700	SOCIAL SERVICE	719	0	719	0	1,368	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,263	173,969	67,263	44,385	212,845	30.00
31.00	03100	INTENSIVE CARE UNIT	6,909	18,456	6,909	3,864	40,184	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,877	0	6,877	0	41,237	35.00
43.00	04300	NURSERY	12,388	47,964	12,388	0	24,821	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,512	115,521	26,512	0	107,481	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,083	17,034	14,083	2,993	57,734	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,253	37,899	14,253	0	49,471	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	345	2,141	345	0	12,115	54.02
57.00	05700	CT SCAN	3,847	7,539	3,847	0	14,725	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,968	12,279	7,968	0	7,258	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,827	0	4,827	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,378	288	2,378	0	22,725	65.00
66.00	06600	PHYSICAL THERAPY	2,022	745	2,022	0	14,243	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	22	8	22	0	150	68.00
69.00	06900	ELECTROCARDIOLOGY	254	40	254	0	1,998	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17	3	17	0	124	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	12,677	23,079	12,677	0	89,922	75.00
76.00	03330	ENDOSCOPY	5,261	33,457	5,261	0	53,515	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,615	60,406	13,615	0	34,550	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	235,535	565,341	228,665	51,242	892,904	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,654	0	1,654	0	5,908	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	7,876	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	885	0	885	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	1,736	2,593	1,736	0	4,110	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,880,768	940,796	2,681,551	1,913,787	1,061,708	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.692582	1.656523	11.511767	37.348015	1.165690	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,004,782	70,575	202,239	226,728	235,290	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.189909	0.124266	0.868202	4.424652	0.258334	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: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/22/2021 12:34 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT REVENUE)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	746,599					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	626	22,288,735				14.00
15.00	01500	PHARMACY	1,163	111,135	4,993,511			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	663,833,096		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	13,896	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	287,485	494,790	0	62,257,392	3,119	30.00
31.00	03100	INTENSIVE CARE UNIT	73,375	195,582	0	15,295,515	1,426	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	54,783	74,277	0	16,660,880	2,315	35.00
43.00	04300	NURSERY	42,775	4,527	0	8,041,814	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	95,019	4,380,691	0	209,410,715	273	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	81,220	226,971	0	42,369,997	1,758	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,249	397,389	0	27,491,707	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	1,139	0	3,719,129	0	54.02
57.00	05700	CT SCAN	8	81,327	0	9,696,148	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3	42,558	0	3,406,905	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	562	0	44,198,427	0	60.00
65.00	06500	RESPIRATORY THERAPY	339	145,155	0	9,027,633	0	65.00
66.00	06600	PHYSICAL THERAPY	0	16,170	0	3,638,966	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	179	0	137,037	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7	25,344	0	4,273,339	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	900	0	1,192,851	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,310,888	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,437,607	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,993,511	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	3,206,891	0	96,115,111	0	75.00
76.00	03330	ENDOSCOPY	26,058	895,600	0	59,878,372	728	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	58,135	206,255	0	47,021,158	3,548	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	731,245	22,255,937	4,993,511	663,833,096	13,167	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32,798	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,239	0	0	0	729	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	13,115	0	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	0	0	0	0	194.06
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)	3,325,335	1,377,982	3,808,187	21,167	201,755	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.453977	0.061824	0.762627	0.000032	14.518926	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	227,390	267,786	396,710	8,766	24,836	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.304568	0.012014	0.079445	0.000013	1.787277	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/22/2021 12:34 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,761,442		22,761,442	0	22,761,442	30.00
31.00	03100	INTENSIVE CARE UNIT	5,259,771		5,259,771	0	5,259,771	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	3,659,909		3,659,909	0	3,659,909	35.00
43.00	04300	NURSERY	2,750,239		2,750,239	0	2,750,239	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,703,753		17,703,753	0	17,703,753	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,057,617		6,057,617	335	6,057,952	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,433,911		5,433,911	7,122	5,441,033	54.00
54.01	03480	ONCOLOGY	0		0	0	0	54.01
54.02	05402	ULTRASOUND	470,078		470,078	0	470,078	54.02
57.00	05700	CT SCAN	1,592,247		1,592,247	0	1,592,247	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,571,811		1,571,811	0	1,571,811	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	4,501,957		4,501,957	0	4,501,957	60.00
65.00	06500	RESPIRATORY THERAPY	1,983,578	0	1,983,578	0	1,983,578	65.00
66.00	06600	PHYSICAL THERAPY	1,139,600	0	1,139,600	0	1,139,600	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,089	0	12,089	0	12,089	68.00
69.00	06900	ELECTROCARDIOLOGY	270,946		270,946	0	270,946	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,346		29,346	0	29,346	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,195,334		7,195,334	0	7,195,334	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,638,472		8,638,472	0	8,638,472	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,200,141		10,200,141	0	10,200,141	73.00
75.00	07500	ASC (NON-DISTINCT PART)	14,120,358		14,120,358	0	14,120,358	75.00
76.00	03330	ENDOSCOPY	6,350,757		6,350,757	0	6,350,757	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,777,468		4,777,468	0	4,777,468	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,900,885		2,900,885		2,900,885	92.00
200.00		Subtotal (see instructions)	129,381,709	0	129,381,709	7,457	129,389,166	200.00
201.00		Less Observation Beds	2,900,885		2,900,885		2,900,885	201.00
202.00		Total (see instructions)	126,480,824	0	126,480,824	7,457	126,488,281	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/22/2021 12:34 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,561,277		51,561,277			30.00
31.00	03100	INTENSIVE CARE UNIT	15,295,515		15,295,515			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	16,660,880		16,660,880			35.00
43.00	04300	NURSERY	8,041,814		8,041,814			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	72,395,924	137,014,791	209,410,715	0.084541	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	41,470,523	899,474	42,369,997	0.142969	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,673,820	24,817,887	27,491,707	0.197656	0.000000	54.00
54.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	54.01
54.02	05402	ULTRASOUND	666,103	3,053,026	3,719,129	0.126395	0.000000	54.02
57.00	05700	CT SCAN	1,712,319	7,983,829	9,696,148	0.164214	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	230,351	3,176,553	3,406,904	0.461361	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	22,671,605	21,526,823	44,198,428	0.101858	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,003,008	3,024,625	9,027,633	0.219723	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,619,505	2,019,461	3,638,966	0.313166	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	108,711	28,326	137,037	0.088217	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,125,837	3,147,502	4,273,339	0.063404	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	381,065	811,786	1,192,851	0.024602	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,706,749	28,664,192	46,370,941	0.155169	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,598,947	7,933,747	21,532,694	0.401179	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,685,928	14,098,016	39,783,944	0.256388	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	96,115,111	96,115,111	0.146911	0.000000	75.00
76.00	03330	ENDOSCOPY	2,581,952	57,296,420	59,878,372	0.106061	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,788,281	39,232,877	47,021,158	0.101603	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,372,016	8,324,099	10,696,115	0.271209	0.000000	92.00
200.00		Subtotal (see instructions)	312,352,130	459,168,545	771,520,675			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	312,352,130	459,168,545	771,520,675			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/22/2021 12:34 pm

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.084541		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.142977		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197915		54.00
54.01	03480	ONCOLOGY	0.000000		54.01
54.02	05402	ULTRASOUND	0.126395		54.02
57.00	05700	CT SCAN	0.164214		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.461361		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.101858		60.00
65.00	06500	RESPIRATORY THERAPY	0.219723		65.00
66.00	06600	PHYSICAL THERAPY	0.313166		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.088217		68.00
69.00	06900	ELECTROCARDIOLOGY	0.063404		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.024602		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.155169		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.401179		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.256388		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.146911		75.00
76.00	03330	ENDOSCOPY	0.106061		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.101603		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.271209		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/22/2021 12:34 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,761,442		22,761,442	0	22,761,442	30.00
31.00	03100	INTENSIVE CARE UNIT	5,259,771		5,259,771	0	5,259,771	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	3,659,909		3,659,909	0	3,659,909	35.00
43.00	04300	NURSERY	2,750,239		2,750,239	0	2,750,239	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,703,753		17,703,753	0	17,703,753	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,057,617		6,057,617	335	6,057,952	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,433,911		5,433,911	7,122	5,441,033	54.00
54.01	03480	ONCOLOGY	0		0	0	0	54.01
54.02	05402	ULTRASOUND	470,078		470,078	0	470,078	54.02
57.00	05700	CT SCAN	1,592,247		1,592,247	0	1,592,247	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,571,811		1,571,811	0	1,571,811	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	4,501,957		4,501,957	0	4,501,957	60.00
65.00	06500	RESPIRATORY THERAPY	1,983,578	0	1,983,578	0	1,983,578	65.00
66.00	06600	PHYSICAL THERAPY	1,139,600	0	1,139,600	0	1,139,600	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,089	0	12,089	0	12,089	68.00
69.00	06900	ELECTROCARDIOLOGY	270,946		270,946	0	270,946	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,346		29,346	0	29,346	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,195,334		7,195,334	0	7,195,334	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,638,472		8,638,472	0	8,638,472	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,200,141		10,200,141	0	10,200,141	73.00
75.00	07500	ASC (NON-DISTINCT PART)	14,120,358		14,120,358	0	14,120,358	75.00
76.00	03330	ENDOSCOPY	6,350,757		6,350,757	0	6,350,757	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,777,468		4,777,468	0	4,777,468	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,900,885		2,900,885		2,900,885	92.00
200.00		Subtotal (see instructions)	129,381,709	0	129,381,709	7,457	129,389,166	200.00
201.00		Less Observation Beds	2,900,885		2,900,885		2,900,885	201.00
202.00		Total (see instructions)	126,480,824	0	126,480,824	7,457	126,488,281	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/22/2021 12:34 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,561,277		51,561,277			30.00
31.00	03100	INTENSIVE CARE UNIT	15,295,515		15,295,515			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	16,660,880		16,660,880			35.00
43.00	04300	NURSERY	8,041,814		8,041,814			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	72,395,924	137,014,791	209,410,715	0.084541	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	41,470,523	899,474	42,369,997	0.142969	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,673,820	24,817,887	27,491,707	0.197656	0.000000	54.00
54.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	54.01
54.02	05402	ULTRASOUND	666,103	3,053,026	3,719,129	0.126395	0.000000	54.02
57.00	05700	CT SCAN	1,712,319	7,983,829	9,696,148	0.164214	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	230,351	3,176,553	3,406,904	0.461361	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	22,671,605	21,526,823	44,198,428	0.101858	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,003,008	3,024,625	9,027,633	0.219723	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,619,505	2,019,461	3,638,966	0.313166	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	108,711	28,326	137,037	0.088217	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,125,837	3,147,502	4,273,339	0.063404	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	381,065	811,786	1,192,851	0.024602	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,706,749	28,664,192	46,370,941	0.155169	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,598,947	7,933,747	21,532,694	0.401179	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,685,928	14,098,016	39,783,944	0.256388	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	96,115,111	96,115,111	0.146911	0.000000	75.00
76.00	03330	ENDOSCOPY	2,581,952	57,296,420	59,878,372	0.106061	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,788,281	39,232,877	47,021,158	0.101603	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,372,016	8,324,099	10,696,115	0.271209	0.000000	92.00
200.00		Subtotal (see instructions)	312,352,130	459,168,545	771,520,675			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	312,352,130	459,168,545	771,520,675			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/22/2021 12:34 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03480	ONCOLOGY	0.000000		54.01
54.02	05402	ULTRASOUND	0.000000		54.02
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03330	ENDOSCOPY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part I Date/Time Prepared: 11/22/2021 12:34 pm

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)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,890,997	0	2,890,997	16,446	175.79	30.00
31.00	INTENSIVE CARE UNIT	486,593		486,593	1,920	253.43	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	342,321		342,321	1,910	179.23	35.00
43.00	NURSERY	439,364		439,364	2,822	155.69	43.00
200.00	Total (lines 30 through 199)	4,159,275		4,159,275	23,098		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	3,281	576,767				30.00
31.00	INTENSIVE CARE UNIT	1,455	368,741				31.00
35.00	NEONATAL INTENSIVE CARE UNIT	0	0				35.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	4,736	945,508				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part II Date/Time Prepared: 11/22/2021 12:34 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,542,785	209,410,715	0.012143	18,508,091	224,744	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	654,197	42,369,997	0.015440	50,602	781	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	829,664	27,491,707	0.030179	953,573	28,778	54.00
54.01	03480	ONCOLOGY	0	0	0.000000	0	0	54.01
54.02	05402	ULTRASOUND	112,278	3,719,129	0.030189	219,426	6,624	54.02
57.00	05700	CT SCAN	334,380	9,696,148	0.034486	737,140	25,421	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	560,335	3,406,904	0.164470	75,704	12,451	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	239,503	44,198,428	0.005419	6,542,303	35,453	60.00
65.00	06500	RESPIRATORY THERAPY	222,235	9,027,633	0.024617	2,019,123	49,705	65.00
66.00	06600	PHYSICAL THERAPY	87,328	3,638,966	0.023998	693,952	16,653	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	941	137,037	0.006867	49,748	342	68.00
69.00	06900	ELECTROCARDIOLOGY	29,619	4,273,339	0.006931	419,804	2,910	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,588	1,192,851	0.008876	209,762	1,862	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	227,544	46,370,941	0.004907	2,961,505	14,532	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	273,840	21,532,694	0.012717	6,205,897	78,920	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	549,122	39,783,944	0.013803	5,933,506	81,900	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,030,783	96,115,111	0.010724	0	0	75.00
76.00	03330	ENDOSCOPY	539,983	59,878,372	0.009018	843,997	7,611	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	563,113	47,021,158	0.011976	3,181,063	38,096	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	368,450	10,696,115	0.034447	769,054	26,492	92.00
200.00		Total (lines 50 through 199)	9,176,688	679,961,189		50,374,250	653,275	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part III Date/Time Prepared: 11/22/2021 12:34 pm

Title XVIII | 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
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00
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	16,446	0.00	3,281	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,920	0.00	1,455	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	1,910	0.00	0	35.00
43.00	04300	NURSERY		0	2,822	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	23,098		4,736	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
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	35.00
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: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/22/2021 12:34 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	0	0	0	0	54.02
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
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03330	ENDOSCOPY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/22/2021 12:34 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	209,410,715	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	42,369,997	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	27,491,707	0.000000	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0.000000	54.01
54.02	05402	ULTRASOUND	0	0	0	3,719,129	0.000000	54.02
57.00	05700	CT SCAN	0	0	0	9,696,148	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,406,904	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	44,198,428	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,027,633	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,638,966	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	137,037	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,273,339	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,192,851	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	46,370,941	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,532,694	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	39,783,944	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	96,115,111	0.000000	75.00
76.00	03330	ENDOSCOPY	0	0	0	59,878,372	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	47,021,158	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	10,696,115	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	679,961,189		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/22/2021 12:34 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	18,508,091	0	20,492,416	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	50,602	0	28,799	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	953,573	0	1,611,037	0	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.000000	219,426	0	796,775	0	54.02
57.00	05700	CT SCAN	0.000000	737,140	0	2,099,788	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	75,704	0	651,186	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	6,542,303	0	5,088,469	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,019,123	0	864,055	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	693,952	0	38,904	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	49,748	0	2,516	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	419,804	0	740,135	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	209,762	0	157,357	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,961,505	0	2,389,498	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,205,897	0	1,657,706	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,933,506	0	2,875,816	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03330	ENDOSCOPY	0.000000	843,997	0	4,584,615	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	3,181,063	0	7,825,184	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	769,054	0	2,176,479	0	92.00
200.00		Total (lines 50 through 199)		50,374,250	0	54,080,735	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/22/2021 12:34 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.084541	20,492,416	0	0	1,732,449	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.142969	28,799	0	0	4,117	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197656	1,611,037	0	0	318,431	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.126395	796,775	0	0	100,708	54.02
57.00	05700	CT SCAN	0.164214	2,099,788	0	0	344,815	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.461361	651,186	0	0	300,432	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.101858	5,088,469	308	0	518,301	60.00
65.00	06500	RESPIRATORY THERAPY	0.219723	864,055	0	0	189,853	65.00
66.00	06600	PHYSICAL THERAPY	0.313166	38,904	0	0	12,183	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.088217	2,516	0	0	222	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063404	740,135	0	0	46,928	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.024602	157,357	0	0	3,871	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.155169	2,389,498	0	0	370,776	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.401179	1,657,706	0	0	665,037	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.256388	2,875,816	0	6,548	737,325	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.146911	0	0	0	0	75.00
76.00	03330	ENDOSCOPY	0.106061	4,584,615	0	0	486,249	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.101603	7,825,184	0	0	795,062	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.271209	2,176,479	0	0	590,281	92.00
200.00		Subtotal (see instructions)		54,080,735	308	6,548	7,217,040	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		54,080,735	308	6,548	7,217,040	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/22/2021 12:34 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03480	ONCOLOGY	0	0		54.01
54.02	05402	ULTRASOUND	0	0		54.02
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	31	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,679		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03330	ENDOSCOPY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
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)	31	1,679		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	31	1,679		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/22/2021 12:34 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.084541	0	1,137,229	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.142969	0	13,803	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197656	0	89,363	0	0	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.126395	0	22,842	0	0	54.02
57.00	05700	CT SCAN	0.164214	0	64,868	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.461361	0	18,565	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.101858	0	235,983	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.219723	0	30,365	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.313166	0	8,617	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.088217	0	560	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063404	0	25,544	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.024602	0	1,098	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.155169	0	234,248	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.401179	0	62,717	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.256388	0	111,377	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.146911	0	962,990	0	0	75.00
76.00	03330	ENDOSCOPY	0.106061	0	206,452	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.101603	0	632,681	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.271209	0	59,295	0	0	92.00
200.00		Subtotal (see instructions)		0	3,918,597	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	3,918,597	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/22/2021 12:34 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	96,142	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,973	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,663	0		54.00
54.01	03480	ONCOLOGY	0	0		54.01
54.02	05402	ULTRASOUND	2,887	0		54.02
57.00	05700	CT SCAN	10,652	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,565	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	24,037	0		60.00
65.00	06500	RESPIRATORY THERAPY	6,672	0		65.00
66.00	06600	PHYSICAL THERAPY	2,699	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	49	0		68.00
69.00	06900	ELECTROCARDIOLOGY	1,620	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	27	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,348	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,161	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,556	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	141,474	0		75.00
76.00	03330	ENDOSCOPY	21,897	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	64,282	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	16,081	0		92.00
200.00		Subtotal (see instructions)	506,785	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	506,785	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0157	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/22/2021 12:34 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	16,446	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	16,446	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)	14,350	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)	3,281	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	22,761,442	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)	22,761,442	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	22,761,442	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,384.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,540,937	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)	4,540,937	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/22/2021 12:34 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,259,771	1,920	2,739.46	1,455	3,985,914	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	NEONATAL INTENSIVE CARE UNIT	3,659,909	1,910	1,916.18	0	0	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	8,399,672	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	16,926,523	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)	945,508	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	653,275	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,598,783	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	15,327,740	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)	2,096	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,384.01	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,900,885	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/22/2021 12:34 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,890,997	22,761,442	0.127013	2,900,885	368,450	90.00
91.00	Nursing School cost	0	22,761,442	0.000000	2,900,885	0	91.00
92.00	Allied health cost	0	22,761,442	0.000000	2,900,885	0	92.00
93.00	All other Medical Education	0	22,761,442	0.000000	2,900,885	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0157	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/22/2021 12:34 pm
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	16,446	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	16,446	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)	14,350	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)	153	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	2,822	15.00
16.00	Nursery days (title V or XIX only)	56	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	22,761,442	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)	22,761,442	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	22,761,442	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,384.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	211,754	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)	211,754	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/22/2021 12:34 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	2,750,239	2,822	974.57	56	54,576	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,259,771	1,920	2,739.46	73	199,981	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	NEONATAL INTENSIVE CARE UNIT	3,659,909	1,910	1,916.18	376	720,484	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	502,805	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,689,600	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,096	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,384.01	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,900,885	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/22/2021 12:34 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,890,997	22,761,442	0.127013	2,900,885	368,450	90.00
91.00	Nursing School cost	0	22,761,442	0.000000	2,900,885	0	91.00
92.00	Allied health cost	0	22,761,442	0.000000	2,900,885	0	92.00
93.00	All other Medical Education	0	22,761,442	0.000000	2,900,885	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 11/22/2021 12:34 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		13,373,400		30.00
31.00	03100	INTENSIVE CARE UNIT		4,393,904		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0		35.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.084541	18,508,091	1,564,693	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.142977	50,602	7,235	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197915	953,573	188,726	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	54.01
54.02	05402	ULTRASOUND	0.126395	219,426	27,734	54.02
57.00	05700	CT SCAN	0.164214	737,140	121,049	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.461361	75,704	34,927	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.101858	6,542,303	666,386	60.00
65.00	06500	RESPIRATORY THERAPY	0.219723	2,019,123	443,648	65.00
66.00	06600	PHYSICAL THERAPY	0.313166	693,952	217,322	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.088217	49,748	4,389	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063404	419,804	26,617	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.024602	209,762	5,161	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.155169	2,961,505	459,534	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.401179	6,205,897	2,489,676	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.256388	5,933,506	1,521,280	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.146911	0	0	75.00
76.00	03330	ENDOSCOPY	0.106061	843,997	89,515	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.101603	3,181,063	323,206	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.271209	769,054	208,574	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		50,374,250	8,399,672	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)		50,374,250		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 11/22/2021 12:34 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,044,823		30.00
31.00	03100	INTENSIVE CARE UNIT		260,747		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		3,112,546		35.00
43.00	04300	NURSERY		197,950		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.084541	775,662	65,575	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.142969	312,142	44,627	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197656	84,449	16,692	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	54.01
54.02	05402	ULTRASOUND	0.126395	25,867	3,269	54.02
57.00	05700	CT SCAN	0.164214	34,757	5,708	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.461361	9,990	4,609	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.101858	590,581	60,155	60.00
65.00	06500	RESPIRATORY THERAPY	0.219723	297,274	65,318	65.00
66.00	06600	PHYSICAL THERAPY	0.313166	54,622	17,106	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.088217	5,425	479	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063404	27,596	1,750	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.024602	10,508	259	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.155169	132,319	20,532	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.401179	107,501	43,127	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.256388	454,578	116,548	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.146911	0	0	75.00
76.00	03330	ENDOSCOPY	0.106061	66,666	7,071	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.101603	295,067	29,980	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.271209	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,285,004	502,805	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)		3,285,004		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0157	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/22/2021 12:34 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,898,354	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	9,635,632	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)	49,007	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	205,639	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)	147.26	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.84	30.00
31.00	Percentage of Medicaid patient days (see instructions)	15.83	31.00
32.00	Sum of lines 30 and 31	18.67	32.00
33.00	Allowable disproportionate share percentage (see instructions)	4.89	33.00
34.00	Disproportionate share adjustment (see instructions)	153,229	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0157	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/22/2021 12:34 pm
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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	8,350,599,096	8,290,014,521	35.00
35.01	Factor 3 (see instructions)	0.000197126	0.000252548	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,646,116	2,093,629	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	413,778	1,565,919	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,979,697		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		40.00

		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	14,921,558		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)	14,921,558	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,055,559	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	0	53.00
54.00	Special add-on payments for new technologies	97,095	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	16,074,212	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	16,074,212	61.00
62.00	Deductibles billed to program beneficiaries	1,242,500	62.00
63.00	Coinsurance billed to program beneficiaries	6,954	63.00
64.00	Allowable bad debts (see instructions)	49,072	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	31,897	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26,146	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	14,856,655	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-18,037	70.93
70.94	HRR adjustment amount (see instructions)	-23,108	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0157	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/22/2021 12:34 pm
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		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)		14,815,510	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		14,587,031	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)		228,479	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		218,456	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/22/2021 12:34 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,898,354	0	2,898,354		2,898,354	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,635,632	0		9,635,632	9,635,632	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	49,007	0	49,007		49,007	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	205,639	0		205,639	205,639	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0489	0.0489	0.0489	0.0489		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	153,229	0	35,433	117,796	153,229	11.00
11.01	Uncompensated care payments	36.00	1,979,697	0	413,778	1,565,919	1,979,697	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	14,921,558	0	3,396,572	11,524,986	14,921,558	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	14,921,558	0	3,396,572	11,524,986	14,921,558	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,055,559	0	246,980	808,579	1,055,559	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/22/2021 12:34 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	97,095	0	0	97,095	97,095	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,643,552	12,430,660	16,074,212	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	968,518	0	230,114	738,404	968,518	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	49,753	0	8,007	41,746	49,753	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0385	0.0385	0.0385	0.0385		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	37,288	0	8,859	28,429	37,288	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,055,559	0	246,980	808,579	1,055,559	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/22/2021 12:34 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,898,354	2,898,354		2,898,354	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,635,632		9,635,632	9,635,632	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	49,007	49,007		49,007	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	205,639		205,639	205,639	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0489	0.0489	0.0489		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	153,229	35,433	117,796	153,229	11.00
11.01	Uncompensated care payments	36.00	1,979,697	413,778	1,565,919	1,979,697	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	14,921,558	3,396,572	11,524,986	14,921,558	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	14,921,558	3,396,572	11,524,986	14,921,558	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,055,559	246,980	808,579	1,055,559	16.00
17.00	Special add-on payments for new technologies	54.00	97,095	0	97,095	97,095	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			3,643,552	12,430,660	16,074,212	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/22/2021 12:34 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	968,518	230,114	738,404	968,518	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	49,753	8,007	41,746	49,753	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0385	0.0385	0.0385		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	37,288	8,859	28,429	37,288	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,055,559	246,980	808,579	1,055,559	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-18,037	15,836	-33,873	-18,037	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-23,108	-7,536	-15,572	-23,108	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E Part B Date/Time Prepared: 11/22/2021 12:34 pm

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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,710	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,217,040	2.00
3.00	OPPS payments	6,863,941	3.00
4.00	Outlier payment (see instructions)	59,569	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)	1,710	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	6,856	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)	6,856	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	6,856	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	5,146	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)	1,710	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)	6,923,510	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,273,029	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)	5,652,191	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)	5,652,191	30.00
31.00	Primary payer payments	3,393	31.00
32.00	Subtotal (line 30 minus line 31)	5,648,798	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	87,870	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	57,116	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	72,506	36.00
37.00	Subtotal (see instructions)	5,705,914	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-25	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)	5,705,939	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	5,648,398	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	57,541	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 15-0157	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part I Date/Time Prepared: 11/22/2021 12:34 pm
	Title XVIII	Hospital	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		14,587,031		5,648,398	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		14,587,031		5,648,398	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		228,479		57,541	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		14,815,510		5,705,939	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0157	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part II Date/Time Prepared: 11/22/2021 12:34 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0157	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/22/2021 12:34 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	1,689,600		1.00
2.00	Medical and other services		506,785	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	1,689,600	506,785	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	1,689,600	506,785	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	3,285,004	3,918,597	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)	3,285,004	3,918,597	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	3,285,004	3,918,597	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,595,404	3,411,812	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	1,689,600	506,785	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	1,689,600	506,785	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,689,600	506,785	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	1,689,600	506,785	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	1,689,600	506,785	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	1,689,600	506,785	40.00
41.00	Interim payments	1,689,600	506,785	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: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G | Date/Time Prepared: 11/22/2021 12:34 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	8,505,320	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	69,064,986	0	0	0	4.00
5.00	Other receivable	1,926,554	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-30,984,236	0	0	0	6.00
7.00	Inventory	2,699,040	0	0	0	7.00
8.00	Prepaid expenses	354,814	0	0	0	8.00
9.00	Other current assets	77,487	0	0	0	9.00
10.00	Due from other funds	15,625,255	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	67,269,220	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	15,676,014	0	0	0	12.00
13.00	Land improvements	3,511,485	0	0	0	13.00
14.00	Accumulated depreciation	-2,475,775	0	0	0	14.00
15.00	Buildings	87,542,306	0	0	0	15.00
16.00	Accumulated depreciation	-54,276,263	0	0	0	16.00
17.00	Leasehold improvements	3,288,035	0	0	0	17.00
18.00	Accumulated depreciation	-2,728,307	0	0	0	18.00
19.00	Fixed equipment	18,566,156	0	0	0	19.00
20.00	Accumulated depreciation	-7,198,050	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	54,127,003	0	0	0	23.00
24.00	Accumulated depreciation	-42,494,685	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)	73,537,919	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	280,772	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	32,337,076	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	32,337,076	280,772	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	173,144,215	280,772	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,696,731	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,270,820	0	0	0	38.00
39.00	Payroll taxes payable	470,009	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	18,409,373	0	0	0	43.00
44.00	Other current liabilities	18,869,418	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	45,716,351	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	28,447,149	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	28,447,149	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	74,163,500	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	98,980,715				52.00
53.00	Specific purpose fund		280,772			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	98,980,715	280,772	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	173,144,215	280,772	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G-1 | Date/Time Prepared: 11/22/2021 12:34 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		93,267,174		232,862		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		119,640,182				2.00
3.00	Total (sum of line 1 and line 2)		212,907,356		232,862		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	OTHER ACTIVITY	0		21,995		0	5.00
6.00	OTHER ADJUSTMENT (NET INCOME/LOSS NO	0		25,915		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		47,910		10.00
11.00	Subtotal (line 3 plus line 10)		212,907,356		280,772		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	DISTRIBUTIONS	10,435,970		0		0	13.00
14.00	NET ASSET TRANS TO FROM ALPHA	103,490,671		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00	ROUNDING	0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		113,926,641		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		98,980,715		280,772		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	OTHER ACTIVITY		0			5.00
6.00	OTHER ADJUSTMENT (NET INCOME/LOSS NO		0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	DISTRIBUTIONS		0			13.00
14.00	NET ASSET TRANS TO FROM ALPHA		0			14.00
15.00			0			15.00
16.00			0			16.00
17.00	ROUNDING		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: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/22/2021 12:34 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	59,603,091		59,603,091	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	59,603,091		59,603,091	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	15,295,515		15,295,515	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	NEONATAL INTENSIVE CARE UNIT	16,660,880		16,660,880	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	31,956,395		31,956,395	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	91,559,486		91,559,486	17.00
18.00	Ancillary services	210,632,347	411,613,094	622,245,441	18.00
19.00	Outpatient services	10,160,297	47,555,452	57,715,749	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRIVATE OFFICES	0	720,164	720,164	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	312,352,130	459,888,710	772,240,840	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		141,502,217		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		141,502,217		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G-3 | Date/Time Prepared: 11/22/2021 12:34 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	772,240,840	1.00
2.00	Less contractual allowances and discounts on patients' accounts	524,224,289	2.00
3.00	Net patient revenues (line 1 minus line 2)	248,016,551	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	141,502,217	4.00
5.00	Net income from service to patients (line 3 minus line 4)	106,514,334	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	285,690	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	245,970	16.00
17.00	Revenue from sale of drugs to other than patients	831	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	6,921	21.00
22.00	Rental of hospital space	786,315	22.00
23.00	Governmental appropriations	0	23.00
24.00	MEALS ON WHEELS	1,868	24.00
24.01	CONTRACT SERVICES REVENUE	0	24.01
24.02	OTHER MISCELLANEOUS REVENUE	924,897	24.02
24.03	OTHER	0	24.03
24.04	LATE PENALTY FEES	451	24.04
24.05	OTHER NONOPERATING	0	24.05
24.06	CONSOLIDATING AMOUNT	1,110,560	24.06
24.07	SEMINARS TUITION REVENUE	0	24.07
24.08	MEDICAL AFFAIRS ADMIN - ADMIN FEES	500	24.08
24.09	UNCLAIMED PROPERTY EXCEPTION	107,922	24.09
24.10	INTRA/INTERCOMPANY OPERATING REVENUE	139,224	24.10
24.11	AUXILIARY/GIFT SHOP INCOME	35,604	24.11
24.12	BILLING ARRANGEMENTS	606,380	24.12
24.13	UNRESTRICTED DONATIONS REVENEU	0	24.13
24.14	ON SITE CLINICS OTHER REVENUE	129,210	24.14
24.15	ACCOMODATION FEES	0	24.15
24.16	FOUNDATION TRANSFERS	44,774	24.16
24.17	PATIENT INTEREST INCOME	22,444	24.17
24.18	REVENUES FROM EXTERNAL PARTIES	0	24.18
24.19	GAIN ON SALE DISPOSAL PPE	0	24.19
24.20	OTHER (SPECIFY)	0	24.20
24.50	COVID-19 PHE Funding	8,708,236	24.50
25.00	Total other income (sum of lines 6-24)	13,157,797	25.00
26.00	Total (line 5 plus line 25)	119,672,131	26.00
27.00	LOSS FROM UNCONSOLIDATED ENTITIES	0	27.00
27.01	INVESTMENT INCOME NON-HSD	0	27.01
27.02	NET ASSETS REL FROM RESTRICTED FUNDS	31,949	27.02
27.03	DONATIONS	0	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	31,949	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	119,640,182	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0157	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Prepared: 11/22/2021 12:34 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	968,518	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	49,753	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)	54.86	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)	2.84	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	15.83	8.00
9.00	Sum of lines 7 and 8	18.67	9.00
10.00	Allowable disproportionate share percentage (see instructions)	3.85	10.00
11.00	Disproportionate share adjustment (see instructions)	37,288	11.00
12.00	Total prospective capital payments (see instructions)	1,055,559	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00