

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 7/6/2022 10:06 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/6/2022	Time: 10:06 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SSM HEALTH DEPAUL HOSPITAL (26-0104) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	1,685,225	-67,952	0	0	1.00
2.00	Subprovider - IPF	0	-42,261	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
7.00	SKILLED NURSING FACILITY	0	-19,842	0		0	7.00
200.00	Total	0	1,623,122	-67,952	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: 26-0104		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 7/6/2022 10:06 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 12303 DEPAUL DRIVE			PO Box:				1.00		
2.00	City: BRIDGETON			State: MO		Zip Code: 63044		County: ST. LOUIS		
		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		SSM HEALTH DEPAUL HOSPITAL	260104	41180	1	01/01/1966	N	P	O
4.00	Subprovider - IPF		SSM HEALTH DEPAUL HOSPITAL	26S104	41180	4	07/01/1985	N	P	O
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		SSM HEALTH DEPAUL HOSPITAL-ANN HOUSE	265842	41180		09/11/2012	N	P	P
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2021	12/31/2021		20.00
21.00	Type of Control (see instructions)						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 OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N	22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
7/6/2022 10:06 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	14,942	2,534	920	899	9,063	12	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	Y	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
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					Y	Y	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
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		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-0104		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 7/6/2022 10:06 am	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1		60.01	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	
61.01	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
7/6/2022 10:06 am

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	14.25	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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			1.00	2.00	3.00
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.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	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.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
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)				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-0104		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 7/6/2022 10:06 am	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	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	
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
				1.00	2.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	1,106,306	124,812			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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-0104		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 7/6/2022 10:06 am	
		1.00	2.00				
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		269020		140.00	
		1.00	2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: SSM HEALTH CARE CORP	Contractor's Name: WPS		Contractor's Number: 05301		141.00	
142.00	Street: 10101 WOODFIELD LANE	PO Box: PO BOX 86				142.00	
143.00	City: ST. LOUIS	State: MO		Zip Code: 63132		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
				1.00		2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				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	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						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	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			9.99		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 7/6/2022 10:06 am
			Beginning 1.00	Ending 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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 7/6/2022 10:06 am
			Y/N 1.00	Date 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 1.00	Date 2.00	V/I 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 1.00	Type 2.00	Date 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 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	Y	Y	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	Y		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	Y		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 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	04/21/2022	Y
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
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
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
7/6/2022 10:06 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		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.	PATRICIA	RACHELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3142315544	PRACHELL@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
7/6/2022 10:06 am

		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.	MANAGING DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
7/6/2022 10:06 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					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	388	141,620	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)		388	141,620	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	32	11,680	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		420	153,300	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	25	9,125		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	52	18,980		0	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)		497				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: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
7/6/2022 10:06 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	19,752	13,699	92,385		1.00
2.00	HMO and other (see instructions)	28,957	13,416			2.00
3.00	HMO IPF Subprovider	369	170			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)	19,752	13,699	92,385		7.00
8.00	INTENSIVE CARE UNIT	2,166	1,026	7,774		8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY		217	2,404		13.00
14.00	Total (see instructions)	21,918	14,942	102,563	14.25	1,523.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF	1,555	1,218	4,220	0.00	22.09
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY	4,366	11,209	16,810	0.00	0.00
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
27.00	Total (sum of lines 14-26)				14.25	1,545.09
28.00	Observation Bed Days		950	7,022		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			929		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	12	401		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: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
7/6/2022 10:06 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	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	3,812	2,725	20,709	1.00
2.00 HMO and other (see instructions)			4,825	2,675		2.00
3.00 HMO IPF Subprovider				55		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	3,812	2,725	20,709	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	166	186	773	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					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: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
7/6/2022 10:06 am

	Wkst. A Line Number	Amount Reported	Reclassificat ion 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	141,993,785	0	141,993,785	3,501,105.94	40.56 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		255,499	0	255,499	2,249.00	113.61 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		3,139,264	0	3,139,264	17,945.94	174.93 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	1,124,681	0	1,124,681	32,932.42	34.15 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		7,253,659	0	7,253,659	158,090.76	45.88 8.00
9.00	SNF	44.00	2,359,970	0	2,359,970	129,235.16	18.26 9.00
10.00	Excluded area salaries (see instructions)		2,400,912	357,762	2,758,674	82,359.98	33.50 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		10,026,924	0	10,026,924	179,711.55	55.79 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		501,317	0	501,317	3,256.00	153.97 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		27,274,707	0	27,274,707	639,822.29	42.63 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)		50,972,948	0	50,972,948		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		2,758,138	0	2,758,138		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		100,667	0	100,667		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		1,236,870	0	1,236,870		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		336,016	0	336,016		
25.50	Home office wage-related (core)		9,404,929	0	9,404,929		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
7/6/2022 10:06 am

		Wkst. A Line Number	Amount Reported	Reclassificat ion 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	1,300,529	0	1,300,529	10,061.95	129.25	26.00
27.00	Administrative & General	5.00	13,189,474	-419,867	12,769,607	257,179.74	49.65	27.00
28.00	Administrative & General under contract (see inst.)		1,292,597	0	1,292,597	13,109.52	98.60	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,549,058	0	1,549,058	50,859.89	30.46	30.00
31.00	Laundry & Linen Service	8.00	149,555	0	149,555	8,868.15	16.86	31.00
32.00	Housekeeping	9.00	2,716,383	0	2,716,383	152,302.33	17.84	32.00
33.00	Housekeeping under contract (see instructions)		101,279	0	101,279	3,369.00	30.06	33.00
34.00	Dietary	10.00	2,514,283	-1,461,211	1,053,072	60,878.10	17.30	34.00
35.00	Dietary under contract (see instructions)		248,599	0	248,599	6,855.00	36.27	35.00
36.00	Cafeteria	11.00	0	1,461,211	1,461,211	84,472.54	17.30	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	4,131,130	0	4,131,130	75,713.99	54.56	38.00
39.00	Central Services and Supply	14.00	332,100	419,867	751,967	38,995.72	19.28	39.00
40.00	Pharmacy	15.00	5,921,715	274,461	6,196,176	138,997.20	44.58	40.00
41.00	Medical Records & Medical Records Library	16.00	368,566	0	368,566	19,456.99	18.94	41.00
42.00	Social Service	17.00	452,590	0	452,590	14,822.96	30.53	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part III
Date/Time Prepared:
7/6/2022 10:06 am

	Worksheet A Line Number	Amount Reported	Reclassificat ion 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)	132,118,656	0	132,118,656	3,315,470.34	39.85	1.00
2.00	Excluded area salaries (see instructions)	4,760,882	357,762	5,118,644	211,595.14	24.19	2.00
3.00	Subtotal salaries (line 1 minus line 2)	127,357,774	-357,762	127,000,012	3,103,875.20	40.92	3.00
4.00	Subtotal other wages & related costs (see inst.)	37,802,948	0	37,802,948	822,789.84	45.94	4.00
5.00	Subtotal wage-related costs (see inst.)	60,478,544	0	60,478,544	0.00	47.62	5.00
6.00	Total (sum of lines 3 thru 5)	225,639,266	-357,762	225,281,504	3,926,665.04	57.37	6.00
7.00	Total overhead cost (see instructions)	34,267,858	274,461	34,542,319	935,943.08	36.91	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part IV
Date/Time Prepared:
7/6/2022 10:06 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	3,402,176	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	5,710,094	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	0	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)	21,584,278	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	9,428,106	9.00
10.00	Dental, Hearing and Vision Plan	1,322,926	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	119,426	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)	1,330,177	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,918,068	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	9,767,805	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	1,007	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	650,746	22.00
23.00	Tuition Reimbursement	169,829	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	55,404,638	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: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part V
Date/Time Prepared:
7/6/2022 10:06 am

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	10,670,830	55,404,638	1.00
2.00	Hospital	10,026,924	53,538,431	2.00
3.00	SUBPROVIDER - IPF	0	945,369	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	SKILLED NURSING FACILITY	643,906	920,838	8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			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 I	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 7/6/2022 10:06 am	
				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)			0.266835	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			57,276,889	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			2,882,635	5.00
6.00	Medicaid charges			211,122,922	6.00
7.00	Medicaid cost (line 1 times line 6)			56,334,985	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)			0	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)			0	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)	48,555,823	3,106,996	51,662,819	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	12,956,393	3,106,996	16,063,389	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)	12,956,393	3,106,996	16,063,389	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)			37,253,628	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			1,707,426	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			2,626,809	27.01
28.00	Non-Medicare bad debt expense (see instructions)			34,626,819	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			10,159,030	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			26,222,419	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			26,222,419	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-0104

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

Worksheet A

Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (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		8,667,218		8,667,218	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		9,773,962		9,773,962	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,300,529	22,166,772	226,147	23,693,448	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,189,474	85,596,502	-2,097,761	96,688,215	5.00
7.00	00700	OPERATION OF PLANT	1,549,058	9,136,688	0	10,685,746	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	149,555	1,265,072	0	1,414,627	8.00
9.00	00900	HOUSEKEEPING	2,716,383	2,128,729	0	4,845,112	9.00
10.00	01000	DIETARY	2,514,283	3,643,829	-3,578,873	2,579,239	10.00
11.00	01100	CAFETERIA	0	0	3,578,873	3,578,873	11.00
13.00	01300	NURSING ADMINISTRATION	4,131,130	-325,746	3,805,384	3,805,384	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	332,100	1,350,516	2,097,868	3,780,484	14.00
15.00	01500	PHARMACY	5,921,715	47,246,941	-44,220,098	8,948,558	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	368,566	177,394	545,960	545,960	16.00
17.00	01700	SOCIAL SERVICE	452,590	287,946	740,536	740,536	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,124,681	146,233	-146,233	1,124,681	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	146,233	146,233	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	398,047	40,621	-181,426	257,242	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	42,482,557	27,133,499	-2,642,447	66,973,609	30.00
31.00	03100	INTENSIVE CARE UNIT	6,487,798	7,952,609	-2,998,434	11,441,973	31.00
40.00	04000	SUBPROVIDER - IPF	1,883,651	838,987	697,733	3,420,371	40.00
43.00	04300	NURSERY	271,534	28,272	299,806	876,065	43.00
44.00	04400	SKILLED NURSING FACILITY	2,359,970	2,499,103	-147,558	4,711,515	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,508,727	34,662,588	-26,762,406	17,408,909	50.00
51.00	05100	RECOVERY ROOM	926,938	118,055	-38,971	1,006,022	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,976,784	1,094,192	-1,901,674	2,169,302	52.00
52.01	05201	PERINATAL CLINIC	703,823	611,725	-15,743	1,299,805	52.01
53.00	05300	ANESTHESIOLOGY	85,730	5,486,514	-828,036	4,744,208	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,926,467	10,065,564	-4,444,896	8,547,135	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,318,744	1,281,238	-36,131	3,563,851	55.00
56.00	05600	RADIOISOTOPE	222,487	737,702	-684,882	275,307	56.00
57.00	05700	CT SCAN	960,150	837,564	-496,525	1,301,189	57.00
58.00	05800	MRI	1,202,221	173,684	-77,897	1,298,008	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,316,150	7,624,409	-6,087,984	2,852,575	59.00
60.00	06000	LABORATORY	2,007,669	4,162,620	-1,677,616	4,492,673	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	426,852	1,625,683	978,076	3,030,611	62.00
64.00	06400	INTRAVENOUS THERAPY	2,029,715	1,237,830	-443,562	2,823,983	64.00
65.00	06500	RESPIRATORY THERAPY	3,550,662	2,010,657	-862,509	4,698,810	65.00
66.00	06600	PHYSICAL THERAPY	0	2,464,388	-16,250	2,448,138	66.00
66.01	06601	CLINICAL NUTRITION	537,824	41,227	-337	578,714	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	1,342,424	-20,446	1,321,978	67.00
68.00	06800	SPEECH PATHOLOGY	0	479,712	-1,132	478,580	68.00
69.00	06900	ELECTROCARDIOLOGY	3,283,035	1,985,084	-889,756	4,378,363	69.00
69.01	06901	CARDIAC REHABILITATION	328,504	36,281	-3,498	361,287	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	262,215	110,847	-50,560	322,502	70.00
70.01	07001	ELECTROSHOCK THERAPY	94,678	22,725	-11,057	106,346	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	30,931,463	30,931,463	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	20,861,832	20,861,832	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	44,816,372	44,816,372	73.00
74.00	07400	RENAL DIALYSIS	3,111	2,126,970	-85,826	2,044,255	74.00
76.00	03330	ENDOSCOPY	924,248	987,134	-757,752	1,153,630	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	6,281,653	4,880,230	-1,195,609	9,966,274	90.00
91.00	09100	EMERGENCY	11,362,563	6,529,987	-1,280,824	16,611,726	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)	141,874,571	322,492,181	0	464,366,752	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	19,740	48,897	68,637	68,637	190.00
191.00	19100	RESEARCH	52,273	4,574	56,847	56,847	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	66	66	66	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	47,201	614,150	661,351	661,351	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	20,814,176	20,814,176	20,814,176	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	141,993,785	343,974,044	485,967,829	485,967,829	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-0104

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

Worksheet A

Date/Time Prepared:
7/6/2022 10:06 am

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	-914,593	7,526,478	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,117,561	11,891,523	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,941,410	32,634,858	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,843,572	86,844,643	5.00
7.00	00700	OPERATION OF PLANT	-279,547	10,406,199	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,414,627	8.00
9.00	00900	HOUSEKEEPING	0	4,845,112	9.00
10.00	01000	DIETARY	-1,344,135	1,235,104	10.00
11.00	01100	CAFETERIA	0	3,578,873	11.00
13.00	01300	NURSING ADMINISTRATION	-100,288	3,705,096	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-1	3,780,483	14.00
15.00	01500	PHARMACY	-198,219	8,750,339	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,891	544,069	16.00
17.00	01700	SOCIAL SERVICE	-76,184	664,352	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	-3,000	1,121,681	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	146,233	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	-81	257,161	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-8,265,833	58,707,776	30.00
31.00	03100	INTENSIVE CARE UNIT	-23,230	11,418,743	31.00
40.00	04000	SUBPROVIDER - IPF	119,249	3,539,620	40.00
43.00	04300	NURSERY	0	876,065	43.00
44.00	04400	SKILLED NURSING FACILITY	-179,414	4,532,101	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-523,691	16,885,218	50.00
51.00	05100	RECOVERY ROOM	0	1,006,022	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-10,355	2,158,947	52.00
52.01	05201	PERINATAL CLINIC	-427,739	872,066	52.01
53.00	05300	ANESTHESIOLOGY	-4,034,858	709,350	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-900,488	7,646,647	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-1,608	3,562,243	55.00
56.00	05600	RADIOISOTOPE	-3,593	271,714	56.00
57.00	05700	CT SCAN	-122,212	1,178,977	57.00
58.00	05800	MRI	-880,320	417,688	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,461	2,854,036	59.00
60.00	06000	LABORATORY	-1,974,250	2,518,423	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	-47,096	2,983,515	62.00
64.00	06400	INTRAVENOUS THERAPY	-89,421	2,734,562	64.00
65.00	06500	RESPIRATORY THERAPY	-23,527	4,675,283	65.00
66.00	06600	PHYSICAL THERAPY	0	2,448,138	66.00
66.01	06601	CLINICAL NUTRITION	-75,624	503,090	66.01
67.00	06700	OCCUPATIONAL THERAPY	-1	1,321,977	67.00
68.00	06800	SPEECH PATHOLOGY	0	478,580	68.00
69.00	06900	ELECTROCARDIOLOGY	-632,711	3,745,652	69.00
69.01	06901	CARDIAC REHABILITATION	-7,062	354,225	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-53,413	269,089	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	106,346	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-1,819,987	29,111,476	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,861,832	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	44,816,372	73.00
74.00	07400	RENAL DIALYSIS	-367	2,043,888	74.00
76.00	03330	ENDOSCOPY	-5,839	1,147,791	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-801,148	9,165,126	90.00
91.00	09100	EMERGENCY	-2,980,226	13,631,500	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)	-25,465,843	438,900,909	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	68,637	190.00
191.00	19100	RESEARCH	0	56,847	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	66	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07951	NONREIMBURSABLE	0	661,351	194.00
194.01	07952	NONREIMBURSABLE	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	20,814,176	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-25,465,843	460,501,986	200.00

RECLASSIFICATIONS

Provider CCN: 26-0104

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

Worksheet A-6

Date/Time Prepared:
7/6/2022 10:06 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PHARMACY					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	2,470,904		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	44,816,372		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	107		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
	TOTALS		0	47,287,383		
	B - NURSERY & L&D					
1.00	ADULTS & PEDIATRICS	30.00	1,273,231	1,121,177		1.00
2.00	INTENSIVE CARE UNIT	31.00	14,657	12,984		2.00
3.00	NURSERY	43.00	373,018	203,241		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	TOTALS		1,660,906	1,337,402		
	C - CENTRAL SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	30,931,463		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	20,861,832		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
	TOTALS		0	51,793,295		
	E - BHM - ADMIN					
1.00	PHARMACY	15.00	93,035	30,824		1.00
2.00	ADULTS & PEDIATRICS	30.00	2,945,876	976,026		2.00
3.00	CLINIC	90.00	165,884	54,961		3.00
4.00	EMERGENCY	91.00	105,870	35,077		4.00
5.00	SUBPROVIDER - IPF	40.00	539,188	178,643		5.00
	TOTALS		3,849,853	1,275,531		
	F - PARKING GARAGE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	226,147		1.00
	TOTALS		0	226,147		

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	G - CENTRAL DISTRIBUTION					
	CENTRAL SERVICES & SUPPLY	14.00	419,867	1,677,894		1.00
	TOTALS		419,867	1,677,894		
1.00	H - RESIDENCY ANCILLARY					
	I&R SERVICES-OTHER PRGM	22.00	0	146,233		1.00
	COSTS APPRV					
	TOTALS		0	146,233		
1.00	I - PHARMACY RESIDENCY					
	PHARMACY	15.00	181,426	0		1.00
	TOTALS		181,426	0		
1.00	J - DIETARY					
	CAFETERIA	11.00	1,461,211	2,117,662		1.00
	TOTALS		1,461,211	2,117,662		
500.00	Grand Total: Increases		7,573,263	105,861,547		500.00

RECLASSIFICATIONS

Provider CCN: 26-0104

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

Worksheet A-6

Date/Time Prepared:
7/6/2022 10:06 am

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00			10.00
	A - PHARMACY						
1.00	PHARMACY	15.00	0	44,525,383	0	1.00	
2.00	ADULTS & PEDIATRICS	30.00	0	355	0	2.00	
3.00	INTENSIVE CARE UNIT	31.00	0	652	0	3.00	
4.00	SKILLED NURSING FACILITY	44.00	0	147,558	0	4.00	
5.00	OPERATING ROOM	50.00	0	22,061	0	5.00	
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	46	0	6.00	
7.00	PERINATAL CLINIC	52.01	0	50	0	7.00	
8.00	ANESTHESIOLOGY	53.00	0	4,000	0	8.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	24,182	0	9.00	
10.00	RADIOLOGY-THERAPEUTIC	55.00	0	8,205	0	10.00	
11.00	RADIOISOTOPE	56.00	0	132	0	11.00	
12.00	CARDIAC CATHETERIZATION	59.00	0	7,905	0	12.00	
13.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	1,290,260	0	13.00	
14.00	RESPIRATORY THERAPY	65.00	0	471	0	14.00	
15.00	ELECTROCARDIOLOGY	69.00	0	1,643	0	15.00	
16.00	CARDIAC REHABILITATION	69.01	0	216	0	16.00	
17.00	ENDOSCOPY	76.00	0	2	0	17.00	
18.00	CLINIC	90.00	0	1,252,125	0	18.00	
19.00	EMERGENCY	91.00	0	2,137	0	19.00	
	TOTALS		0	47,287,383			
	B - NURSERY & L&D						
1.00	ADULTS & PEDIATRICS	30.00	18,164	15,671	0	1.00	
2.00	INTENSIVE CARE UNIT	31.00	614,071	761,886	0	2.00	
3.00	DELIVERY ROOM & LABOR ROOM	52.00	1,028,310	558,121	0	3.00	
4.00	CARDIAC CATHETERIZATION	59.00	271	1,675	0	4.00	
5.00	EMERGENCY	91.00	90	49	0	5.00	
	TOTALS		1,660,906	1,337,402			
	C - CENTRAL SUPPLY						
1.00	ADULTS & PEDIATRICS	30.00	0	3,800,976	0	1.00	
2.00	INTENSIVE CARE UNIT	31.00	0	1,649,466	0	2.00	
3.00	SUBPROVIDER - IPF	40.00	0	20,098	0	3.00	
4.00	OPERATING ROOM	50.00	0	26,740,345	0	4.00	
5.00	RECOVERY ROOM	51.00	0	38,971	0	5.00	
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	315,197	0	6.00	
7.00	PERINATAL CLINIC	52.01	0	15,693	0	7.00	
8.00	ANESTHESIOLOGY	53.00	0	824,036	0	8.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,420,714	0	9.00	
10.00	RADIOLOGY-THERAPEUTIC	55.00	0	27,926	0	10.00	
11.00	RADIOISOTOPE	56.00	0	684,750	0	11.00	
12.00	CT SCAN	57.00	0	496,525	0	12.00	
13.00	MRI	58.00	0	77,897	0	13.00	
14.00	CARDIAC CATHETERIZATION	59.00	0	6,078,133	0	14.00	
15.00	LABORATORY	60.00	0	1,677,616	0	15.00	
16.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	202,568	0	16.00	
17.00	INTRAVENOUS THERAPY	64.00	0	443,562	0	17.00	
18.00	RESPIRATORY THERAPY	65.00	0	862,038	0	18.00	
19.00	PHYSICAL THERAPY	66.00	0	16,250	0	19.00	
20.00	CLINICAL NUTRITION	66.01	0	337	0	20.00	
21.00	OCCUPATIONAL THERAPY	67.00	0	20,446	0	21.00	
22.00	SPEECH PATHOLOGY	68.00	0	1,132	0	22.00	
23.00	ELECTROCARDIOLOGY	69.00	0	888,113	0	23.00	
24.00	CARDIAC REHABILITATION	69.01	0	3,282	0	24.00	
25.00	ELECTROENCEPHALOGRAPHY	70.00	0	48,767	0	25.00	
26.00	ELECTROSHOCK THERAPY	70.01	0	11,057	0	26.00	
27.00	RENAL DIALYSIS	74.00	0	85,826	0	27.00	
28.00	ENDOSCOPY	76.00	0	757,750	0	28.00	
29.00	CLINIC	90.00	0	164,329	0	29.00	
30.00	EMERGENCY	91.00	0	1,419,495	0	30.00	
	TOTALS		0	51,793,295			
	E - BHM - ADMIN						
1.00	ADULTS & PEDIATRICS	30.00	3,848,775	1,274,816	0	1.00	
2.00	ELECTROENCEPHALOGRAPHY	70.00	1,078	715	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	
	TOTALS		3,849,853	1,275,531			
	F - PARKING GARAGE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	226,147	9	1.00	
	TOTALS		0	226,147			

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
1.00	G - CENTRAL DISTRIBUTION					1.00
	ADMINISTRATIVE & GENERAL	5.00	419,867	1,677,894	0	
	TOTALS		419,867	1,677,894		
1.00	H - RESIDENCY ANCILLARY					1.00
	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	146,233	0	
	TOTALS		0	146,233		
1.00	I - PHARMACY RESIDENCY					1.00
	PHARMACY RESIDENCY PRGM	23.00	181,426	0	0	
	TOTALS		181,426	0		
1.00	J - DIETARY					1.00
	DIETARY	10.00	1,461,211	2,117,662	0	
	TOTALS		1,461,211	2,117,662		
500.00	Grand Total: Decreases		7,573,263	105,861,547		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part I
Date/Time Prepared:
7/6/2022 10:06 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	9,615,392	0	0	0	0	1.00
2.00	Land Improvements	3,089,466	56,389	0	56,389	0	2.00
3.00	Buildings and Fixtures	130,039,469	6,796,386	0	6,796,386	382,435	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,621,199	124,029	0	124,029	0	5.00
6.00	Movable Equipment	104,641,641	8,899,858	-9,219	8,890,639	1,752,314	6.00
7.00	HIT designated Assets	1,228,069	277,023	0	277,023	0	7.00
8.00	Subtotal (sum of lines 1-7)	253,235,236	16,153,685	-9,219	16,144,466	2,134,749	8.00
9.00	Reconciling Items	2,943,301	1,155,267	0	1,155,267	37,012	9.00
10.00	Total (line 8 minus line 9)	250,291,935	14,998,418	-9,219	14,989,199	2,097,737	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	9,615,392	0				1.00
2.00	Land Improvements	3,145,855	0				2.00
3.00	Buildings and Fixtures	136,453,420	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	4,745,228	0				5.00
6.00	Movable Equipment	111,779,966	0				6.00
7.00	HIT designated Assets	1,505,092	0				7.00
8.00	Subtotal (sum of lines 1-7)	267,244,953	0				8.00
9.00	Reconciling Items	4,061,556	0				9.00
10.00	Total (line 8 minus line 9)	263,183,397	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part II
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	7,260,759	0	1,406,459	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,773,962	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	17,034,721	0	1,406,459	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed 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	8,667,218				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9,773,962				2.00
3.00	Total (sum of lines 1-2)	0	18,441,180				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part III
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	149,214,666	0	149,214,666	0.558344	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	118,030,286	0	118,030,286	0.441656	0	2.00
3.00	Total (sum of lines 1-2)	267,244,952	0	267,244,952	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	7,526,440	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	11,891,523	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	19,417,963	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	38	0	0	0	7,526,478	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	11,891,523	2.00
3.00	Total (sum of lines 1-2)	38	0	0	0	19,418,001	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-0104

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

Worksheet A-8

Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0	0.00	0	7.00
8.00	Television and radio service (chapter 21)			0	0.00	0	8.00
9.00	Parking lot (chapter 21)			0	0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-17,984,045			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	4,084,525			0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests			0	0.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00	Sale of drugs to other than patients			0	0.00	0	17.00
18.00	Sale of medical records and abstracts			0	0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00	Vending machines			0	0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL 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			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-0104

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

Worksheet A-8

Date/Time Prepared:
7/6/2022 10:06 am

31.00	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
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	BAD DEBT	A	128,704	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	BAD DEBT	A	-20,393	SKILLED NURSING FACILITY	44.00	0	33.01
33.02	GIFT	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	GIFT	A	-572,121	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	GIFT	A	-6,081	NURSING ADMINISTRATION	13.00	0	33.04
33.05	GIFT	A	-818	PHARMACY	15.00	0	33.05
33.06	GIFT	A	-81	PHARMACY RESIDENCY PRGM	23.00	0	33.06
33.07	GIFT	A	-136	ADULTS & PEDIATRICS	30.00	0	33.07
33.08	GIFT	A	-2,599	INTENSIVE CARE UNIT	31.00	0	33.08
33.09	GIFT	A	-70,725	SKILLED NURSING FACILITY	44.00	0	33.09
33.10	GIFT	A	-827	OPERATING ROOM	50.00	0	33.10
33.11	GIFT	A	-355	DELIVERY ROOM & LABOR ROOM	52.00	0	33.11
33.12	GIFT	A	-948	CARDIAC CATHETERIZATION	59.00	0	33.12
33.13	GIFT	A	-789	RESPIRATORY THERAPY	65.00	0	33.13
33.14	GIFT	A	-132	ELECTROCARDIOLOGY	69.00	0	33.14
33.15	GIFT	A	-694	CLINIC	90.00	0	33.15
33.19	PHONE	A	-15,374	SKILLED NURSING FACILITY	44.00	0	33.19
33.20	ENTERTAINMENT	A	-100,018	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	ENTERTAINMENT	A	-14	ADULTS & PEDIATRICS	30.00	0	33.21
33.22	ENTERTAINMENT	A	-76	INTENSIVE CARE UNIT	31.00	0	33.22
33.23	ENTERTAINMENT	A	-354	SKILLED NURSING FACILITY	44.00	0	33.23
33.24	ENTERTAINMENT	A	-4,290	RADIOLOGY-DIAGNOSTIC	54.00	0	33.24
33.27	ENTERTAINMENT	A	-6	CLINIC	90.00	0	33.27
33.31	NURSE PRACTITIONER	A	-169,325	ADULTS & PEDIATRICS	30.00	0	33.31
33.32	NURSE PRACTITIONER	A	-41,184	PERINATAL CLINIC	52.01	0	33.32
33.33	NURSE PRACTITIONER	A	-72,672	CLINIC	90.00	0	33.33
33.34	NURSE PRACTITIONER	A	-111,573	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.34
33.35	NON-MEDICAL TRANSPORT	A	-76,184	SOCIAL SERVICE	17.00	0	33.35
33.36	NON-MEDICAL TRANSPORT	A	-131,495	ADULTS & PEDIATRICS	30.00	0	33.36
33.37	NON-MEDICAL TRANSPORT	A	-762	SKILLED NURSING FACILITY	44.00	0	33.37
33.38	NON-MEDICAL TRANSPORT	A	-95,691	CLINIC	90.00	0	33.38
33.39	MARKETING	A	-9,167	ADMINISTRATIVE & GENERAL	5.00	0	33.39
33.40	MARKETING	A	-31,193	SKILLED NURSING FACILITY	44.00	0	33.40
33.42	MARKETING	A	-49	DELIVERY ROOM & LABOR ROOM	52.00	0	33.42
33.43	MARKETING	A	-11	RADIOLOGY-THERAPEUTIC	55.00	0	33.43
33.44	MARKETING	A	-237	CLINIC	90.00	0	33.44
33.45	MARKETING	A	-84	EMERGENCY	91.00	0	33.45
33.46	FRA	A	-20,721	ADMINISTRATIVE & GENERAL	5.00	0	33.46
33.47	MISCELLANEOUS REVENUE	B	-3,037,260	ADMINISTRATIVE & GENERAL	5.00	0	33.47
33.48	MISCELLANEOUS REVENUE	B	-279,547	OPERATION OF PLANT	7.00	0	33.48
33.49	MISCELLANEOUS REVENUE	B	-1,344,135	DIETARY	10.00	0	33.49
33.51	MISCELLANEOUS REVENUE	B	-94,207	NURSING ADMINISTRATION	13.00	0	33.51
33.52	MISCELLANEOUS REVENUE	B	-1	CENTRAL SERVICES & SUPPLY	14.00	0	33.52
33.53	MISCELLANEOUS REVENUE	B	-196,501	PHARMACY	15.00	0	33.53
33.54	MISCELLANEOUS REVENUE	B	-1,891	MEDICAL RECORDS & LIBRARY	16.00	0	33.54
33.55	MISCELLANEOUS REVENUE	B	-3,000	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	33.55
33.56	MISCELLANEOUS REVENUE	B	-43	ADULTS & PEDIATRICS	30.00	0	33.56
33.57	MISCELLANEOUS REVENUE	B	-20,555	INTENSIVE CARE UNIT	31.00	0	33.57
33.58	MISCELLANEOUS REVENUE	B	-486	SUBPROVIDER - IPF	40.00	0	33.58
33.59	MISCELLANEOUS REVENUE	B	-40,613	SKILLED NURSING FACILITY	44.00	0	33.59
33.60	MISCELLANEOUS REVENUE	B	-463,406	OPERATING ROOM	50.00	0	33.60
33.61	MISCELLANEOUS REVENUE	B	-9,951	DELIVERY ROOM & LABOR ROOM	52.00	0	33.61
33.62	MISCELLANEOUS REVENUE	B	-3,544	PERINATAL CLINIC	52.01	0	33.62
33.63	MISCELLANEOUS REVENUE	B	-17,639	ANESTHESIOLOGY	53.00	0	33.63
33.64	MISCELLANEOUS REVENUE	B	-832,489	RADIOLOGY-DIAGNOSTIC	54.00	0	33.64
33.65	MISCELLANEOUS REVENUE	B	-33,129	RADIOLOGY-THERAPEUTIC	55.00	0	33.65
33.66	MISCELLANEOUS REVENUE	B	-3,593	RADIOISOTOPE	56.00	0	33.66
33.67	MISCELLANEOUS REVENUE	B	-122,212	CT SCAN	57.00	0	33.67
33.68	MISCELLANEOUS REVENUE	B	-39,905	MRI	58.00	0	33.68
33.69	MISCELLANEOUS REVENUE	B	5,423	CARDIAC CATHETERIZATION	59.00	0	33.69

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-0104

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

Worksheet A-8

Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.70	MISCELLANEOUS REVENUE	B	-1,710,898	LABORATORY	60.00	0	33.70
33.71	MISCELLANEOUS REVENUE	B	-47,096	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	33.71
33.72	MISCELLANEOUS REVENUE	B	-89,421	INTRAVENOUS THERAPY	64.00	0	33.72
33.73	MISCELLANEOUS REVENUE	B	-14,466	RESPIRATORY THERAPY	65.00	0	33.73
33.74	MISCELLANEOUS REVENUE	B	-75,624	CLINICAL NUTRITION	66.01	0	33.74
33.75	MISCELLANEOUS REVENUE	B	-1	OCCUPATIONAL THERAPY	67.00	0	33.75
33.76	MISCELLANEOUS REVENUE	B	-6,597	ELECTROCARDIOLOGY	69.00	0	33.76
33.77	MISCELLANEOUS REVENUE	B	0	ELECTROENCEPHALOGRAPHY	70.00	0	33.77
33.78	MISCELLANEOUS REVENUE	B	-367	RENAL DIALYSIS	74.00	0	33.78
33.79	MISCELLANEOUS REVENUE	B	-5,839	ENDOSCOPY	76.00	0	33.79
33.80	MISCELLANEOUS REVENUE	B	-449,257	CLINIC	90.00	0	33.80
33.81	MISCELLANEOUS REVENUE	B	-10,341	EMERGENCY	91.00	0	33.81
33.82	LOBBYING	A	-28,126	ADMINISTRATIVE & GENERAL	5.00	0	33.82
33.83	MISC MD COMPENSATION	A	0	CLINIC	90.00	0	33.83
33.84	PHYSICIAN BENEFITS	A	-1,125,377	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.84
33.85	TV	A	-14,087	ADMINISTRATIVE & GENERAL	5.00	0	33.85
33.86	PHONE	A	-21,667	ADMINISTRATIVE & GENERAL	5.00	0	33.86
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-25,465,843				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: 26-0104

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

Worksheet A-8-1

Date/Time Prepared:
7/6/2022 10:06 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	491,828	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	2,117,561	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	0	1,406,421	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	10,178,360	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	36,013,174	42,746,445	4.01
4.02	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	-1,819,987	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	NETWORK--CORP 130	9,898,100	8,975,098	4.03
4.04	30.00	ADULTS & PEDIATRICS	NETWORK--CORP 130	831,960	754,380	4.04
4.05	40.00	SUBPROVIDER - IPF	NETWORK--CORP 130	2,400,297	2,176,469	4.05
4.06	55.00	RADIOLOGY-THERAPEUTIC	NETWORK--CORP 130	379,047	343,700	4.06
4.07	70.00	ELECTROENCEPHALOGRAPHY	NETWORK--CORP 130	-35,412	-32,110	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			60,454,928	56,370,403	5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	G	SSM HEALTH	100.00	FRAN SISTERS SM	100.00	6.00
7.00	G	SSM HEALTH	100.00	FRAN SISTERS SM	100.00	7.00
8.00	G	SSM HEALTH	100.00	FRAN SISTERS SM	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00
		HOME OFFICE				

(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: 26-0104

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

Worksheet A-8-1

Date/Time Prepared:
7/6/2022 10:06 am

	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	491,828	9		1.00
2.00	2,117,561	9		2.00
3.00	-1,406,421	11		3.00
4.00	10,178,360	0		4.00
4.01	-6,733,271	0		4.01
4.02	-1,819,987	0		4.02
4.03	923,002	0		4.03
4.04	77,580	0		4.04
4.05	223,828	0		4.05
4.06	35,347	0		4.06
4.07	-3,302	0		4.07
5.00	4,084,525			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	STL NETWORK		7.00
8.00	SSM HOSPITALS		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: 26-0104

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

Worksheet A-8-2

Date/Time Prepared:
7/6/2022 10:06 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	620,571	317,448	303,123	211,500	2,574	1.00
2.00	15.00	PHARMACY	900	900	0	211,500	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	8,087,787	8,028,988	58,799	197,500	478	3.00
4.00	40.00	SUBPROVIDER - IPF	104,093	104,093	0	181,300	0	4.00
5.00	50.00	OPERATING ROOM	65,158	59,458	5,700	246,400	57	5.00
6.00	52.01	PERINATAL CLINIC	383,011	383,011	0	237,100	0	6.00
7.00	53.00	ANESTHESIOLOGY	4,051,402	3,992,002	59,400	239,400	297	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	63,709	63,709	0	271,900	0	8.00
9.00	55.00	RADIOLOGY-THERAPEUTIC	43,162	0	43,162	271,900	301	9.00
10.00	58.00	MRI	840,415	840,415	0	271,900	0	10.00
11.00	59.00	CARDIAC CATHETERIZATION	5,454	0	5,454	211,500	24	11.00
12.00	60.00	LABORATORY	283,852	263,352	20,500	260,300	205	12.00
13.00	65.00	RESPIRATORY THERAPY	25,660	0	25,660	211,500	171	13.00
14.00	69.00	ELECTROCARDIOLOGY	669,400	590,380	79,020	211,500	427	14.00
15.00	69.01	CARDIAC REHABILITATION	12,654	0	12,654	211,500	55	15.00
16.00	70.00	ELECTROENCEPHALOGRAPHY	142,744	0	142,744	211,500	911	16.00
17.00	90.00	CLINIC	183,161	182,561	600	197,500	6	17.00
18.00	91.00	EMERGENCY	2,969,801	2,969,801	0	197,500	0	18.00
200.00			18,552,934	17,796,118	756,816		5,506	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	261,731	13,087	0	0	0	1.00
2.00	15.00	PHARMACY	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	45,387	2,269	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	6,752	338	0	0	0	5.00
6.00	52.01	PERINATAL CLINIC	0	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	34,183	1,709	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	8.00
9.00	55.00	RADIOLOGY-THERAPEUTIC	39,347	1,967	0	0	0	9.00
10.00	58.00	MRI	0	0	0	0	0	10.00
11.00	59.00	CARDIAC CATHETERIZATION	2,440	122	0	0	0	11.00
12.00	60.00	LABORATORY	25,655	1,283	0	0	0	12.00
13.00	65.00	RESPIRATORY THERAPY	17,388	869	0	0	0	13.00
14.00	69.00	ELECTROCARDIOLOGY	43,418	2,171	0	0	0	14.00
15.00	69.01	CARDIAC REHABILITATION	5,592	280	0	0	0	15.00
16.00	70.00	ELECTROENCEPHALOGRAPHY	92,633	4,632	0	0	0	16.00
17.00	90.00	CLINIC	570	29	0	0	0	17.00
18.00	91.00	EMERGENCY	0	0	0	0	0	18.00
200.00			575,096	28,756	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	261,731	41,392	358,840		1.00
2.00	15.00	PHARMACY	0	0	0	900		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	45,387	13,412	8,042,400		3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	104,093		4.00
5.00	50.00	OPERATING ROOM	0	6,752	0	59,458		5.00
6.00	52.01	PERINATAL CLINIC	0	0	0	383,011		6.00
7.00	53.00	ANESTHESIOLOGY	0	34,183	25,217	4,017,219		7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	63,709		8.00
9.00	55.00	RADIOLOGY-THERAPEUTIC	0	39,347	3,815	3,815		9.00
10.00	58.00	MRI	0	0	0	840,415		10.00
11.00	59.00	CARDIAC CATHETERIZATION	0	2,440	3,014	3,014		11.00
12.00	60.00	LABORATORY	0	25,655	0	263,352		12.00
13.00	65.00	RESPIRATORY THERAPY	0	17,388	8,272	8,272		13.00
14.00	69.00	ELECTROCARDIOLOGY	0	43,418	35,602	625,982		14.00
15.00	69.01	CARDIAC REHABILITATION	0	5,592	7,062	7,062		15.00
16.00	70.00	ELECTROENCEPHALOGRAPHY	0	92,633	50,111	50,111		16.00
17.00	90.00	CLINIC	0	570	30	182,591		17.00
18.00	91.00	EMERGENCY	0	0	0	2,969,801		18.00
200.00			0	575,096	187,927	17,984,045		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,526,478	7,526,478			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	11,891,523		11,891,523		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	32,634,858	30,086	47,534	32,712,478	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	86,844,643	1,213,103	1,916,653	3,082,494	5.00
7.00	00700	OPERATION OF PLANT	10,406,199	659,045	1,041,263	374,821	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,414,627	22,665	35,809	36,187	8.00
9.00	00900	HOUSEKEEPING	4,845,112	17,611	27,824	657,275	9.00
10.00	01000	DIETARY	1,235,104	179,166	283,075	254,809	10.00
11.00	01100	CAFETERIA	3,578,873	0	0	353,565	11.00
13.00	01300	NURSING ADMINISTRATION	3,705,096	68,138	107,655	999,597	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,780,483	198,712	313,956	181,951	14.00
15.00	01500	PHARMACY	8,750,339	29,375	46,412	1,499,270	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	544,069	45,370	71,683	89,181	16.00
17.00	01700	SOCIAL SERVICE	664,352	12,351	19,515	109,512	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,121,681	0	0	272,136	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	146,233	12,392	19,580	0	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	257,161	5,537	8,749	52,415	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	58,707,776	1,523,284	2,406,727	10,285,812	30.00
31.00	03100	INTENSIVE CARE UNIT	11,418,743	219,431	346,692	1,424,795	31.00
40.00	04000	SUBPROVIDER - IPF	3,539,620	331,056	523,055	586,247	40.00
43.00	04300	NURSERY	876,065	72,976	115,298	155,960	43.00
44.00	04400	SKILLED NURSING FACILITY	4,532,101	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,885,218	624,214	986,232	2,300,798	50.00
51.00	05100	RECOVERY ROOM	1,006,022	0	0	224,288	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,158,947	347,648	549,269	471,466	52.00
52.01	05201	PERINATAL CLINIC	872,066	157,263	248,469	160,337	52.01
53.00	05300	ANESTHESIOLOGY	709,350	9,212	14,555	20,744	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,646,647	125,942	198,983	692,693	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,562,243	117,975	186,396	561,060	55.00
56.00	05600	RADIOISOTOPE	271,714	15,666	24,751	53,835	56.00
57.00	05700	CT SCAN	1,178,977	123,883	195,731	232,325	57.00
58.00	05800	MRI	417,688	28,645	45,257	87,545	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,854,036	79,892	126,227	318,399	59.00
60.00	06000	LABORATORY	2,518,423	232,668	367,605	485,790	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,983,515	8,553	13,514	103,284	62.00
64.00	06400	INTRAVENOUS THERAPY	2,734,562	40,265	63,617	491,124	64.00
65.00	06500	RESPIRATORY THERAPY	4,675,283	83,454	131,853	859,143	65.00
66.00	06600	PHYSICAL THERAPY	2,448,138	82,218	129,902	0	66.00
66.01	06601	CLINICAL NUTRITION	503,090	0	0	130,136	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,321,977	43,899	69,358	0	67.00
68.00	06800	SPEECH PATHOLOGY	478,580	1,019	1,610	481,209	68.00
69.00	06900	ELECTROCARDIOLOGY	3,745,652	10,046	15,872	724,388	69.00
69.01	06901	CARDIAC REHABILITATION	354,225	98,090	154,978	79,487	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	269,089	7,081	11,188	63,187	70.00
70.01	07001	ELECTROSHOCK THERAPY	106,346	15,954	25,206	22,909	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,111,476	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,861,832	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,816,372	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,043,888	15,254	24,100	753	74.00
76.00	03330	ENDOSCOPY	1,147,791	42,468	67,097	223,638	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	9,165,126	268,425	424,100	1,521,021	90.00
91.00	09100	EMERGENCY	13,631,500	285,624	451,274	2,439,256	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)	438,900,909	7,505,656	11,858,624	32,683,633	438,818,343
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	68,637	17,343	27,402	4,776	190.00
191.00	19100	RESEARCH	56,847	0	0	12,648	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	66	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	661,351	3,479	5,497	11,421	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	20,814,176	0	0	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
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)	460,501,986	7,526,478	11,891,523	32,712,478	460,501,986	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/6/2022 10:06 am

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	93,056,893					5.00
7.00	00700	OPERATION OF PLANT	3,160,946	15,642,274				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	382,233	63,035	1,954,556			8.00
9.00	00900	HOUSEKEEPING	1,405,008	48,980	0	7,001,810		9.00
10.00	01000	DIETARY	494,391	498,300	0	224,658	3,169,503	10.00
11.00	01100	CAFETERIA	995,906	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,236,003	189,507	0	85,439	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,133,337	552,662	0	249,167	0	14.00
15.00	01500	PHARMACY	2,614,948	81,700	0	36,834	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	190,017	126,185	0	56,891	0	16.00
17.00	01700	SOCIAL SERVICE	204,054	34,352	0	15,487	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	352,990	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	45,131	34,466	0	15,539	0	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	82,019	15,401	0	6,944	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,468,151	4,236,591	1,701,340	1,910,068	2,758,887	30.00
31.00	03100	INTENSIVE CARE UNIT	3,396,050	610,287	132,431	275,147	214,750	31.00
40.00	04000	SUBPROVIDER - IPF	1,261,199	920,740	72,030	415,115	116,804	40.00
43.00	04300	NURSERY	309,046	202,961	41,948	91,505	68,023	43.00
44.00	04400	SKILLED NURSING FACILITY	1,147,773	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,266,787	1,736,078	0	782,710	0	50.00
51.00	05100	RECOVERY ROOM	311,581	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	893,310	966,886	6,807	435,920	11,039	52.00
52.01	05201	PERINATAL CLINIC	364,213	437,383	0	197,194	0	52.01
53.00	05300	ANESTHESIOLOGY	190,918	25,621	0	11,551	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,194,260	350,273	0	157,920	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,121,326	328,116	0	147,931	0	55.00
56.00	05600	RADIOISOTOPE	92,682	43,569	0	19,643	0	56.00
57.00	05700	CT SCAN	438,361	344,548	0	155,339	0	57.00
58.00	05800	MRI	146,668	79,667	0	35,918	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	855,632	222,198	0	100,178	0	59.00
60.00	06000	LABORATORY	912,850	647,100	0	291,745	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	787,333	23,789	0	10,725	0	62.00
64.00	06400	INTRAVENOUS THERAPY	843,226	111,987	0	50,489	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,456,143	232,103	0	104,644	0	65.00
66.00	06600	PHYSICAL THERAPY	673,721	228,668	0	103,095	0	66.00
66.01	06601	CLINICAL NUTRITION	160,367	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	363,479	122,092	0	55,045	0	67.00
68.00	06800	SPEECH PATHOLOGY	121,868	2,834	0	1,278	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,138,619	27,939	0	12,596	0	69.00
69.01	06901	CARDIAC REHABILITATION	173,930	272,810	0	122,996	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	88,777	19,695	0	8,879	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	43,158	44,371	0	20,005	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,372,598	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,283,342	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,349,925	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	527,780	42,424	0	19,127	0	74.00
76.00	03330	ENDOSCOPY	375,068	118,113	0	53,251	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,881,694	746,548	0	336,581	0	90.00
91.00	09100	EMERGENCY	4,256,606	794,383	0	358,147	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)	87,565,424	15,584,362	1,954,556	6,975,701	3,169,503	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	29,924	48,236	0	21,747	0	190.00
191.00	19100	RESEARCH	17,600	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	17	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	172,655	9,676	0	4,362	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	5,271,273	0	0	0	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	93,056,893	15,642,274	1,954,556	7,001,810	3,169,503	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	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	4,928,344					11.00
13.00	01300	NURSING ADMINISTRATION	176,234	6,567,669				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	32,079	39,815	6,482,162			14.00
15.00	01500	PHARMACY	264,329	268,859	0	13,592,066		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,723	25,543	0	0	1,164,662	16.00
17.00	01700	SOCIAL SERVICE	19,307	24,695	0	1,748	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	47,979	48,061	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	9,241	11,946	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,813,473	2,752,757	0	300	161,113	30.00
31.00	03100	INTENSIVE CARE UNIT	251,198	335,072	0	245	21,898	31.00
40.00	04000	SUBPROVIDER - IPF	103,358	249,679	0	0	9,056	40.00
43.00	04300	NURSERY	27,497	14,437	0	0	2,555	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	405,642	614,315	0	8,282	116,760	50.00
51.00	05100	RECOVERY ROOM	39,543	56,698	0	0	9,046	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	83,122	14,009	0	17	7,708	52.00
52.01	05201	PERINATAL CLINIC	28,268	35,320	0	19	4,577	52.01
53.00	05300	ANESTHESIOLOGY	3,657	7,444	0	1,502	30,122	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	122,125	192,801	0	9,079	58,276	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	98,918	77,236	0	3,080	37,801	55.00
56.00	05600	RADIOISOTOPE	9,491	15,705	0	50	5,460	56.00
57.00	05700	CT SCAN	40,960	56,443	0	0	51,142	57.00
58.00	05800	MRI	15,435	26,796	0	0	14,774	58.00
59.00	05900	CARDIAC CATHETERIZATION	56,135	85,685	0	2,968	29,716	59.00
60.00	06000	LABORATORY	85,647	124,382	0	0	62,517	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	18,210	19,112	0	843,623	5,677	62.00
64.00	06400	INTRAVENOUS THERAPY	86,588	111,085	0	0	17,008	64.00
65.00	06500	RESPIRATORY THERAPY	151,471	149,744	0	177	25,953	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	6,387	66.00
66.01	06601	CLINICAL NUTRITION	22,944	31,321	0	0	37	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	4,479	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	2,149	68.00
69.00	06900	ELECTROCARDIOLOGY	127,713	216,580	0	617	53,183	69.00
69.01	06901	CARDIAC REHABILITATION	14,014	20,508	0	81	801	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	11,140	13,439	0	0	6,295	70.00
70.01	07001	ELECTROSHOCK THERAPY	4,039	4,307	0	0	333	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	3,903,496	0	20,426	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,578,666	0	27,457	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,265,284	245,636	73.00
74.00	07400	RENAL DIALYSIS	133	0	0	0	4,884	74.00
76.00	03330	ENDOSCOPY	39,428	70,888	0	1	12,159	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	268,164	143,441	0	454,866	18,855	90.00
91.00	09100	EMERGENCY	430,053	666,924	0	127	90,422	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,923,258	6,525,047	6,482,162	13,592,066	1,164,662	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	842	12,164	0	0	0	190.00
191.00	19100	RESEARCH	2,230	4,637	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	2,014	3,047	0	0	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	22,774	0	0	0	194.03
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)	4,928,344	6,567,669	6,482,162	13,592,066	1,164,662	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		PHARMACY RESIDENCY PRGM	
					SERVICES-SALA RY & FRINGES APPRV	SERVICES-OTHE R PRGM COSTS APPRV		
			17.00	19.00	21.00	22.00	23.00	
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	1,105,373					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		0				19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			1,842,847			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				273,341		22.00
23.00	02300	PHARMACY RESIDENCY PRGM					449,413	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	962,169	0	339,080	50,294	149,804	30.00
31.00	03100	INTENSIVE CARE UNIT	74,895	0	0	0	99,870	31.00
40.00	04000	SUBPROVIDER - IPF	40,736	0	0	0	24,967	40.00
43.00	04300	NURSERY	23,723	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	1,362,173	202,045	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,850	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0	0	22,357	3,316	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	44,714	6,632	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	0	66.01
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	99,870	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	74,523	11,054	74,902	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)	1,105,373	0	1,842,847	273,341	449,413	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		PHARMACY RESIDENCY PRGM	
				SERVICES-SALA RY & FRINGES APPRV	SERVICES-OTHE R PRGM COSTS APPRV		
				21.00	22.00		
202.00	TOTAL (sum lines 118 through 201)	1,105,373	0	1,842,847	273,341	449,413	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	PHARMACY RESIDENCY PRGM				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	108,227,626	-389,374	107,838,252	30.00
31.00	03100	INTENSIVE CARE UNIT	18,821,504	0	18,821,504	31.00
40.00	04000	SUBPROVIDER - IPF	8,193,662	0	8,193,662	40.00
43.00	04300	NURSERY	2,001,994	0	2,001,994	43.00
44.00	04400	SKILLED NURSING FACILITY	5,679,874	0	5,679,874	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,291,254	-1,564,218	29,727,036	50.00
51.00	05100	RECOVERY ROOM	1,647,178	0	1,647,178	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,949,998	0	5,949,998	52.00
52.01	05201	PERINATAL CLINIC	2,505,109	0	2,505,109	52.01
53.00	05300	ANESTHESIOLOGY	1,050,349	-25,673	1,024,676	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,800,345	-51,346	11,748,999	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,242,082	0	6,242,082	55.00
56.00	05600	RADIOISOTOPE	552,566	0	552,566	56.00
57.00	05700	CT SCAN	2,817,709	0	2,817,709	57.00
58.00	05800	MRI	898,393	0	898,393	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,731,066	0	4,731,066	59.00
60.00	06000	LABORATORY	5,728,727	0	5,728,727	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,817,335	0	4,817,335	62.00
64.00	06400	INTRAVENOUS THERAPY	4,549,951	0	4,549,951	64.00
65.00	06500	RESPIRATORY THERAPY	7,869,968	0	7,869,968	65.00
66.00	06600	PHYSICAL THERAPY	3,672,129	0	3,672,129	66.00
66.01	06601	CLINICAL NUTRITION	847,895	0	847,895	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,980,329	0	1,980,329	67.00
68.00	06800	SPEECH PATHOLOGY	609,338	0	609,338	68.00
69.00	06900	ELECTROCARDIOLOGY	6,173,075	0	6,173,075	69.00
69.01	06901	CARDIAC REHABILITATION	1,291,920	0	1,291,920	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	498,770	0	498,770	70.00
70.01	07001	ELECTROSHOCK THERAPY	286,628	0	286,628	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,407,996	0	40,407,996	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,751,297	0	28,751,297	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,677,217	0	68,677,217	73.00
74.00	07400	RENAL DIALYSIS	2,678,343	0	2,678,343	74.00
76.00	03330	ENDOSCOPY	2,149,902	0	2,149,902	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	16,228,821	0	16,228,821	90.00
91.00	09100	EMERGENCY	23,564,795	-85,577	23,479,218	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)	433,195,145	-2,116,188	431,078,957	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	231,071	0	231,071	190.00
191.00	19100	RESEARCH	93,962	0	93,962	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	83	0	83	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	873,502	0	873,502	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	26,108,223	0	26,108,223	194.03
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
202.00	TOTAL (sum lines 118 through 201)	460,501,986	-2,116,188	458,385,798		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	30,086	47,534	77,620	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,174,707	1,213,103	1,916,653	4,304,463	5.00
7.00	00700	OPERATION OF PLANT	0	659,045	1,041,263	1,700,308	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	22,665	35,809	58,474	8.00
9.00	00900	HOUSEKEEPING	0	17,611	27,824	45,435	9.00
10.00	01000	DIETARY	1,215	179,166	283,075	463,456	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	68,138	107,655	175,793	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	99,519	198,712	313,956	612,187	14.00
15.00	01500	PHARMACY	670,912	29,375	46,412	746,699	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	45,370	71,683	117,053	16.00
17.00	01700	SOCIAL SERVICE	0	12,351	19,515	31,866	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	20,131	0	0	20,131	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	12,392	19,580	31,972	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	0	5,537	8,749	14,286	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	165	1,523,284	2,406,727	3,930,176	30.00
31.00	03100	INTENSIVE CARE UNIT	0	219,431	346,692	566,123	31.00
40.00	04000	SUBPROVIDER - IPF	0	331,056	523,055	854,111	40.00
43.00	04300	NURSERY	0	72,976	115,298	188,274	43.00
44.00	04400	SKILLED NURSING FACILITY	139,511	0	0	139,511	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,191,817	624,214	986,232	2,802,263	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	347,648	549,269	896,917	52.00
52.01	05201	PERINATAL CLINIC	147,210	157,263	248,469	552,942	52.01
53.00	05300	ANESTHESIOLOGY	114,321	9,212	14,555	138,088	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	292,631	125,942	198,983	617,556	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	699,521	117,975	186,396	1,003,892	55.00
56.00	05600	RADIOISOTOPE	0	15,666	24,751	40,417	56.00
57.00	05700	CT SCAN	0	123,883	195,731	319,614	57.00
58.00	05800	MRI	0	28,645	45,257	73,902	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	79,892	126,227	206,119	59.00
60.00	06000	LABORATORY	65,913	232,668	367,605	666,186	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	8,553	13,514	22,067	62.00
64.00	06400	INTRAVENOUS THERAPY	287,298	40,265	63,617	391,180	64.00
65.00	06500	RESPIRATORY THERAPY	111,053	83,454	131,853	326,360	65.00
66.00	06600	PHYSICAL THERAPY	0	82,218	129,902	212,120	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	43,899	69,358	113,257	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,019	1,610	2,629	68.00
69.00	06900	ELECTROCARDIOLOGY	352,880	10,046	15,872	378,798	69.00
69.01	06901	CARDIAC REHABILITATION	0	98,090	154,978	253,068	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,081	11,188	18,269	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	15,954	25,206	41,160	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	15,254	24,100	39,354	74.00
76.00	03330	ENDOSCOPY	28,451	42,468	67,097	138,016	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	929,360	268,425	424,100	1,621,885	90.00
91.00	09100	EMERGENCY	123,326	285,624	451,274	860,224	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)	6,449,941	7,505,656	11,858,624	25,814,221	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	17,343	27,402	44,745	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	0	3,479	5,497	8,976	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	6,449,941	7,526,478	11,891,523	25,867,942	77,620	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/6/2022 10:06 am

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	4,311,775					5.00
7.00	00700	OPERATION OF PLANT	146,456	1,847,653				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,710	7,446	83,716			8.00
9.00	00900	HOUSEKEEPING	65,098	5,785	0	117,877		9.00
10.00	01000	DIETARY	22,907	58,859	0	3,782	549,608	10.00
11.00	01100	CAFETERIA	46,143	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	57,268	22,384	0	1,438	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	52,511	65,280	0	4,195	0	14.00
15.00	01500	PHARMACY	121,158	9,650	0	620	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,804	14,905	0	958	0	16.00
17.00	01700	SOCIAL SERVICE	9,454	4,058	0	261	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	16,355	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,091	4,071	0	262	0	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	3,800	1,819	0	117	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	855,860	500,423	72,870	32,154	478,405	30.00
31.00	03100	INTENSIVE CARE UNIT	157,349	72,087	5,672	4,632	37,239	31.00
40.00	04000	SUBPROVIDER - IPF	58,435	108,757	3,085	6,989	20,254	40.00
43.00	04300	NURSERY	14,319	23,974	1,797	1,541	11,796	43.00
44.00	04400	SKILLED NURSING FACILITY	53,180	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	244,026	205,064	0	13,177	0	50.00
51.00	05100	RECOVERY ROOM	14,436	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	41,390	114,208	292	7,339	1,914	52.00
52.01	05201	PERINATAL CLINIC	16,875	51,663	0	3,320	0	52.01
53.00	05300	ANESTHESIOLOGY	8,846	3,026	0	194	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	101,666	41,374	0	2,659	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	51,954	38,757	0	2,490	0	55.00
56.00	05600	RADIOISOTOPE	4,294	5,146	0	331	0	56.00
57.00	05700	CT SCAN	20,311	40,698	0	2,615	0	57.00
58.00	05800	MRI	6,796	9,410	0	605	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	39,644	26,246	0	1,687	0	59.00
60.00	06000	LABORATORY	42,295	76,435	0	4,912	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	36,479	2,810	0	181	0	62.00
64.00	06400	INTRAVENOUS THERAPY	39,069	13,228	0	850	0	64.00
65.00	06500	RESPIRATORY THERAPY	67,467	27,416	0	1,762	0	65.00
66.00	06600	PHYSICAL THERAPY	31,215	27,010	0	1,736	0	66.00
66.01	06601	CLINICAL NUTRITION	7,430	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	16,841	14,421	0	927	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,647	335	0	22	0	68.00
69.00	06900	ELECTROCARDIOLOGY	52,756	3,300	0	212	0	69.00
69.01	06901	CARDIAC REHABILITATION	8,059	32,224	0	2,071	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	4,113	2,326	0	149	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	2,000	5,241	0	337	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	341,594	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	244,793	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	525,875	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	24,454	5,011	0	322	0	74.00
76.00	03330	ENDOSCOPY	17,378	13,951	0	896	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	133,517	88,182	0	5,666	0	90.00
91.00	09100	EMERGENCY	197,221	93,832	0	6,029	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)	4,057,339	1,840,812	83,716	117,438	549,608	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,386	5,698	0	366	0	190.00
191.00	19100	RESEARCH	815	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	8,000	1,143	0	73	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	244,234	0	0	0	0	194.03
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)	4,311,775	1,847,653	83,716	117,877	549,608	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	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	46,982					11.00
13.00	01300	NURSING ADMINISTRATION	1,681	260,935				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	306	1,582	736,493			14.00
15.00	01500	PHARMACY	2,522	10,682	0	894,888		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	150	1,015	0	0	143,097	16.00
17.00	01700	SOCIAL SERVICE	184	981	0	115	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	458	1,909	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	88	475	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,265	109,368	0	20	19,742	30.00
31.00	03100	INTENSIVE CARE UNIT	2,397	13,312	0	16	2,683	31.00
40.00	04000	SUBPROVIDER - IPF	986	9,920	0	0	1,110	40.00
43.00	04300	NURSERY	262	574	0	0	313	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,870	24,407	0	545	14,307	50.00
51.00	05100	RECOVERY ROOM	377	2,253	0	0	1,108	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	793	557	0	1	945	52.00
52.01	05201	PERINATAL CLINIC	270	1,403	0	1	561	52.01
53.00	05300	ANESTHESIOLOGY	35	296	0	99	3,691	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,165	7,660	0	598	7,141	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	944	3,069	0	203	4,632	55.00
56.00	05600	RADIOISOTOPE	91	624	0	3	669	56.00
57.00	05700	CT SCAN	391	2,242	0	0	6,267	57.00
58.00	05800	MRI	147	1,065	0	0	1,810	58.00
59.00	05900	CARDIAC CATHETERIZATION	536	3,404	0	195	3,641	59.00
60.00	06000	LABORATORY	817	4,942	0	0	7,661	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	174	759	0	55,544	696	62.00
64.00	06400	INTRAVENOUS THERAPY	826	4,413	0	0	2,084	64.00
65.00	06500	RESPIRATORY THERAPY	1,445	5,949	0	12	3,180	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	783	66.00
66.01	06601	CLINICAL NUTRITION	219	1,244	0	0	4	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	549	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	263	68.00
69.00	06900	ELECTROCARDIOLOGY	1,218	8,605	0	41	6,517	69.00
69.01	06901	CARDIAC REHABILITATION	134	815	0	5	98	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	106	534	0	0	771	70.00
70.01	07001	ELECTROSHOCK THERAPY	39	171	0	0	41	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	443,505	0	2,503	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	292,988	0	3,364	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	807,534	30,485	73.00
74.00	07400	RENAL DIALYSIS	1	0	0	0	598	74.00
76.00	03330	ENDOSCOPY	376	2,816	0	0	1,490	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,558	5,699	0	29,948	2,310	90.00
91.00	09100	EMERGENCY	4,103	26,497	0	8	11,080	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)	46,934	259,242	736,493	894,888	143,097	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	8	483	0	0	0	190.00
191.00	19100	RESEARCH	21	184	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	19	121	0	0	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	905	0	0	0	194.03
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)	46,982	260,935	736,493	894,888	143,097	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		PHARMACY RESIDENCY PRGM	
					SERVICES-SALA RY & FRINGES APPRV	SERVICES-OTHE R PRGM COSTS APPRV		
			17.00	19.00	21.00	22.00	23.00	
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	47,179					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0		39,499			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0			38,396		22.00
23.00	02300	PHARMACY RESIDENCY PRGM	0				20,709	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	41,066					30.00
31.00	03100	INTENSIVE CARE UNIT	3,197					31.00
40.00	04000	SUBPROVIDER - IPF	1,739					40.00
43.00	04300	NURSERY	1,013					43.00
44.00	04400	SKILLED NURSING FACILITY	0					44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0					50.00
51.00	05100	RECOVERY ROOM	0					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	164					52.00
52.01	05201	PERINATAL CLINIC	0					52.01
53.00	05300	ANESTHESIOLOGY	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0					54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0					55.00
56.00	05600	RADIOISOTOPE	0					56.00
57.00	05700	CT SCAN	0					57.00
58.00	05800	MRI	0					58.00
59.00	05900	CARDIAC CATHETERIZATION	0					59.00
60.00	06000	LABORATORY	0					60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0					62.00
64.00	06400	INTRAVENOUS THERAPY	0					64.00
65.00	06500	RESPIRATORY THERAPY	0					65.00
66.00	06600	PHYSICAL THERAPY	0					66.00
66.01	06601	CLINICAL NUTRITION	0					66.01
67.00	06700	OCCUPATIONAL THERAPY	0					67.00
68.00	06800	SPEECH PATHOLOGY	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0					69.00
69.01	06901	CARDIAC REHABILITATION	0					69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0					70.00
70.01	07001	ELECTROSHOCK THERAPY	0					70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0					73.00
74.00	07400	RENAL DIALYSIS	0					74.00
76.00	03330	ENDOSCOPY	0					76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0					90.00
91.00	09100	EMERGENCY	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)	47,179	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0					190.00
191.00	19100	RESEARCH	0					191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0					192.00
193.00	19300	NONPAID WORKERS	0					193.00
194.00	07951	NONREIMBURSABLE	0					194.00
194.01	07952	NONREIMBURSABLE	0					194.01
194.02	07953	NONREIMBURSABLE	0					194.02
194.03	07950	RETAIL PHARMACY	0					194.03
200.00		Cross Foot Adjustments		0	39,499	38,396	20,709	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		PHARMACY RESIDENCY PRGM	
				SERVICES-SALA RY & FRINGES APPRV	SERVICES-OTHE R PRGM COSTS APPRV		
				21.00	22.00		
202.00	TOTAL (sum lines 118 through 201)	47,179	0	39,499	38,396	20,709	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	PHARMACY RESIDENCY PRGM				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,081,769	0	6,081,769	30.00
31.00	03100	INTENSIVE CARE UNIT	868,087	0	868,087	31.00
40.00	04000	SUBPROVIDER - IPF	1,066,777	0	1,066,777	40.00
43.00	04300	NURSERY	244,233	0	244,233	43.00
44.00	04400	SKILLED NURSING FACILITY	192,691	0	192,691	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,313,117	0	3,313,117	50.00
51.00	05100	RECOVERY ROOM	18,706	0	18,706	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,065,638	0	1,065,638	52.00
52.01	05201	PERINATAL CLINIC	627,415	0	627,415	52.01
53.00	05300	ANESTHESIOLOGY	154,324	0	154,324	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	781,462	0	781,462	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,107,272	0	1,107,272	55.00
56.00	05600	RADIOISOTOPE	51,703	0	51,703	56.00
57.00	05700	CT SCAN	392,689	0	392,689	57.00
58.00	05800	MRI	93,943	0	93,943	58.00
59.00	05900	CARDIAC CATHETERIZATION	282,227	0	282,227	59.00
60.00	06000	LABORATORY	804,400	0	804,400	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	118,955	0	118,955	62.00
64.00	06400	INTRAVENOUS THERAPY	452,815	0	452,815	64.00
65.00	06500	RESPIRATORY THERAPY	435,629	0	435,629	65.00
66.00	06600	PHYSICAL THERAPY	272,864	0	272,864	66.00
66.01	06601	CLINICAL NUTRITION	9,206	0	9,206	66.01
67.00	06700	OCCUPATIONAL THERAPY	145,995	0	145,995	67.00
68.00	06800	SPEECH PATHOLOGY	8,896	0	8,896	68.00
69.00	06900	ELECTROCARDIOLOGY	453,165	0	453,165	69.00
69.01	06901	CARDIAC REHABILITATION	296,663	0	296,663	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	26,418	0	26,418	70.00
70.01	07001	ELECTROSHOCK THERAPY	49,043	0	49,043	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	787,602	0	787,602	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	541,145	0	541,145	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,363,894	0	1,363,894	73.00
74.00	07400	RENAL DIALYSIS	69,742	0	69,742	74.00
76.00	03330	ENDOSCOPY	175,454	0	175,454	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,893,373	0	1,893,373	90.00
91.00	09100	EMERGENCY	1,204,780	0	1,204,780	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)	25,452,092	0	25,452,092	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	52,697	0	52,697	190.00
191.00	19100	RESEARCH	1,050	0	1,050	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1	0	1	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	18,359	0	18,359	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	245,139	0	245,139	194.03
200.00		Cross Foot Adjustments	98,604	0	98,604	200.00
201.00		Negative Cost Centers	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
202.00	TOTAL (sum lines 118 through 201)	25,867,942	0	25,867,942		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0104

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

Worksheet B-1

Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	731,241					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		731,241				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,923	2,923	135,194,022			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	117,860	117,860	12,739,317	-93,056,893	367,445,093	5.00
7.00	00700	OPERATION OF PLANT	64,030	64,030	1,549,058	0	12,481,328	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,202	2,202	149,555	0	1,509,288	8.00
9.00	00900	HOUSEKEEPING	1,711	1,711	2,716,383	0	5,547,822	9.00
10.00	01000	DIETARY	17,407	17,407	1,053,072	0	1,952,154	10.00
11.00	01100	CAFETERIA	0	0	1,461,211	0	3,932,438	11.00
13.00	01300	NURSING ADMINISTRATION	6,620	6,620	4,131,130	0	4,880,486	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,306	19,306	751,967	0	4,475,102	14.00
15.00	01500	PHARMACY	2,854	2,854	6,196,176	0	10,325,396	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,408	4,408	368,566	0	750,303	16.00
17.00	01700	SOCIAL SERVICE	1,200	1,200	452,590	0	805,730	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	1,124,681	0	1,393,817	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,204	1,204	0	0	178,205	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	538	538	216,621	0	323,862	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	147,996	147,996	42,509,215	0	72,923,599	30.00
31.00	03100	INTENSIVE CARE UNIT	21,319	21,319	5,888,384	0	13,409,661	31.00
40.00	04000	SUBPROVIDER - IPF	32,164	32,164	2,422,839	0	4,979,978	40.00
43.00	04300	NURSERY	7,090	7,090	644,552	0	1,220,299	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	4,532,101	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	60,646	60,646	9,508,727	0	20,796,462	50.00
51.00	05100	RECOVERY ROOM	0	0	926,938	0	1,230,310	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,776	33,776	1,948,474	0	3,527,330	52.00
52.01	05201	PERINATAL CLINIC	15,279	15,279	662,639	0	1,438,135	52.01
53.00	05300	ANESTHESIOLOGY	895	895	85,730	0	753,861	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,236	12,236	2,862,758	0	8,664,265	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,462	11,462	2,318,744	0	4,427,674	55.00
56.00	05600	RADIOISOTOPE	1,522	1,522	222,487	0	365,966	56.00
57.00	05700	CT SCAN	12,036	12,036	960,150	0	1,730,916	57.00
58.00	05800	MRI	2,783	2,783	361,806	0	579,135	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,762	7,762	1,315,879	0	3,378,554	59.00
60.00	06000	LABORATORY	22,605	22,605	2,007,669	0	3,604,486	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	831	831	426,852	0	3,108,866	62.00
64.00	06400	INTRAVENOUS THERAPY	3,912	3,912	2,029,715	0	3,329,568	64.00
65.00	06500	RESPIRATORY THERAPY	8,108	8,108	3,550,662	0	5,749,733	65.00
66.00	06600	PHYSICAL THERAPY	7,988	7,988	0	0	2,660,258	66.00
66.01	06601	CLINICAL NUTRITION	0	0	537,824	0	633,226	66.01
67.00	06700	OCCUPATIONAL THERAPY	4,265	4,265	0	0	1,435,234	67.00
68.00	06800	SPEECH PATHOLOGY	99	99	0	0	481,209	68.00
69.00	06900	ELECTROCARDIOLOGY	976	976	2,993,749	0	4,495,958	69.00
69.01	06901	CARDIAC REHABILITATION	9,530	9,530	328,504	0	686,780	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	688	688	261,137	0	350,545	70.00
70.01	07001	ELECTROSHOCK THERAPY	1,550	1,550	94,678	0	170,415	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	29,111,476	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	20,861,832	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	44,816,372	73.00
74.00	07400	RENAL DIALYSIS	1,482	1,482	3,111	0	2,083,995	74.00
76.00	03330	ENDOSCOPY	4,126	4,126	924,248	0	1,480,994	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	26,079	26,079	6,286,067	0	11,378,672	90.00
91.00	09100	EMERGENCY	27,750	27,750	10,080,943	0	16,807,654	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)	729,218	729,218	135,074,808	-93,056,893	345,761,450	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,685	1,685	19,740	0	118,158	190.00
191.00	19100	RESEARCH	0	0	52,273	0	69,495	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	66	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	338	338	47,201	0	681,748	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0	20,814,176	194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0104

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

Worksheet B-1

Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,526,478	11,891,523	32,712,478		93,056,893	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.292746	16.262112	0.241967		0.253254	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			77,620		4,311,775	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000574		0.011734	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: 26-0104

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

Worksheet B-1

Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
		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	546,428				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,202	115,135			8.00
9.00	00900	HOUSEKEEPING	1,711	0	542,515		9.00
10.00	01000	DIETARY	17,407	0	17,407	115,135	10.00
11.00	01100	CAFETERIA	0	0	0	115,525,426	11.00
13.00	01300	NURSING ADMINISTRATION	6,620	0	6,620	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,306	0	19,306	0	14.00
15.00	01500	PHARMACY	2,854	0	2,854	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,408	0	4,408	0	16.00
17.00	01700	SOCIAL SERVICE	1,200	0	1,200	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	1,124,681	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,204	0	1,204	0	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	538	0	538	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	147,996	100,219	147,996	100,219	30.00
31.00	03100	INTENSIVE CARE UNIT	21,319	7,801	21,319	7,801	31.00
40.00	04000	SUBPROVIDER - IPF	32,164	4,243	32,164	4,243	40.00
43.00	04300	NURSERY	7,090	2,471	7,090	2,471	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	60,646	0	60,646	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,776	401	33,776	401	52.00
52.01	05201	PERINATAL CLINIC	15,279	0	15,279	0	52.01
53.00	05300	ANESTHESIOLOGY	895	0	895	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,236	0	12,236	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,462	0	11,462	0	55.00
56.00	05600	RADIOISOTOPE	1,522	0	1,522	0	56.00
57.00	05700	CT SCAN	12,036	0	12,036	0	57.00
58.00	05800	MRI	2,783	0	2,783	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,762	0	7,762	0	59.00
60.00	06000	LABORATORY	22,605	0	22,605	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	831	0	831	0	62.00
64.00	06400	INTRAVENOUS THERAPY	3,912	0	3,912	0	64.00
65.00	06500	RESPIRATORY THERAPY	8,108	0	8,108	0	65.00
66.00	06600	PHYSICAL THERAPY	7,988	0	7,988	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	537,824	66.01
67.00	06700	OCCUPATIONAL THERAPY	4,265	0	4,265	0	67.00
68.00	06800	SPEECH PATHOLOGY	99	0	99	0	68.00
69.00	06900	ELECTROCARDIOLOGY	976	0	976	0	69.00
69.01	06901	CARDIAC REHABILITATION	9,530	0	9,530	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	688	0	688	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	1,550	0	1,550	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,482	0	1,482	0	74.00
76.00	03330	ENDOSCOPY	4,126	0	4,126	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	26,079	0	26,079	0	90.00
91.00	09100	EMERGENCY	27,750	0	27,750	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)	544,405	115,135	540,492	115,135	115,406,212
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,685	0	1,685	0	190.00
191.00	19100	RESEARCH	0	0	0	52,273	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	338	0	338	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0104

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

Worksheet B-1

Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATI ENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATI ENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	15,642,274	1,954,556	7,001,810	3,169,503	4,928,344	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.626414	16.976211	12.906205	27.528579	0.042660	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,847,653	83,716	117,877	549,608	46,982	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.381329	0.727112	0.217279	4.773596	0.000407	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: 26-0104

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

Worksheet B-1

Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description			NURSING ADMINISTRATIO N (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	
			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	875,254					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,306	52,219,445				14.00
15.00	01500	PHARMACY	35,830	0	36,204,213			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,404	0	0	1,640,590,255		16.00
17.00	01700	SOCIAL SERVICE	3,291	0	4,656	0	115,135	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	6,405	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	1,592	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	366,852	0	798	226,920,244	100,219	30.00
31.00	03100	INTENSIVE CARE UNIT	44,654	0	652	30,842,505	7,801	31.00
40.00	04000	SUBPROVIDER - IPF	33,274	0	0	12,754,523	4,243	40.00
43.00	04300	NURSERY	1,924	0	0	3,598,636	2,471	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	81,868	0	22,061	164,450,796	0	50.00
51.00	05100	RECOVERY ROOM	7,556	0	0	12,740,384	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,867	0	46	10,856,890	401	52.00
52.01	05201	PERINATAL CLINIC	4,707	0	50	6,446,062	0	52.01
53.00	05300	ANESTHESIOLOGY	992	0	4,000	42,425,329	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,694	0	24,182	82,078,986	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	10,293	0	8,205	53,240,477	0	55.00
56.00	05600	RADIOISOTOPE	2,093	0	132	7,690,439	0	56.00
57.00	05700	CT SCAN	7,522	0	0	72,030,933	0	57.00
58.00	05800	MRI	3,571	0	0	20,808,152	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	11,419	0	7,905	41,853,890	0	59.00
60.00	06000	LABORATORY	16,576	0	0	88,052,308	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,547	0	2,247,096	7,995,806	0	62.00
64.00	06400	INTRAVENOUS THERAPY	14,804	0	0	23,954,635	0	64.00
65.00	06500	RESPIRATORY THERAPY	19,956	0	471	36,553,936	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,995,765	0	66.00
66.01	06601	CLINICAL NUTRITION	4,174	0	0	51,612	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,308,343	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,026,407	0	68.00
69.00	06900	ELECTROCARDIOLOGY	28,863	0	1,643	74,905,206	0	69.00
69.01	06901	CARDIAC REHABILITATION	2,733	0	216	1,128,114	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,791	0	0	8,865,577	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	574	0	0	469,676	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	31,446,032	0	28,769,708	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,773,413	0	38,671,723	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	32,670,167	346,187,685	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	6,878,825	0	74.00
76.00	03330	ENDOSCOPY	9,447	0	2	17,125,434	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	19,116	0	1,211,594	26,556,310	0	90.00
91.00	09100	EMERGENCY	88,879	0	337	127,354,939	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)	869,574	52,219,445	36,204,213	1,640,590,255	115,135	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEN	1,621	0	0	0	0	190.00
191.00	19100	RESEARCH	618	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	406	0	0	0	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	3,035	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0104

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

Worksheet B-1

Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description		NURSING ADMINISTRATIO N (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	6,567,669	6,482,162	13,592,066	1,164,662	1,105,373	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7.503729	0.124133	0.375428	0.000710	9.600669	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	260,935	736,493	894,888	143,097	47,179	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.298125	0.014104	0.024718	0.000087	0.409771	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: 26-0104

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

Worksheet B-1

Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description			INTERNS & RESIDENTS			PHARMACY RESIDENCY PRGM (ASSIGNED TIME)		
			NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	SERVICES-SALA RY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHE R PRGM COSTS APPRV (ASSIGNED TIME)			
			19.00	21.00	22.00	23.00		
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						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		3,462				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			3,462			22.00
23.00	02300	PHARMACY RESIDENCY PRGM				432		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	637	637	144		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	96		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	24		40.00
43.00	04300	NURSERY	0	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,559	2,559	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
52.01	05201	PERINATAL CLINIC	0	0	0	0		52.01
53.00	05300	ANESTHESIOLOGY	0	42	42	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	84	84	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	96		69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
76.00	03330	ENDOSCOPY	0	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	140	140	72		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)	0	3,462	3,462	432		118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07951	NONREIMBURSABLE	0	0	0	0		194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0		194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0		194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0		194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0104

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

Worksheet B-1

Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description			INTERNS & RESIDENTS					
			NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	SERVICES-SALA RY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHE R PRGM COSTS APPRV (ASSIGNED TIME)	PHARMACY RESIDENCY PRGM (ASSIGNED TIME)		
			19.00	21.00	22.00	23.00		
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,842,847	273,341	449,413		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	532.307048	78.954650	1,040.307870		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	39,499	38,396	20,709		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	11.409301	11.090699	47.937500		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/6/2022 10:06 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
1.00			2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	107,838,252		107,838,252	13,412	107,851,664	30.00
31.00	03100	INTENSIVE CARE UNIT	18,821,504		18,821,504	0	18,821,504	31.00
40.00	04000	SUBPROVIDER - IPF	8,193,662		8,193,662	0	8,193,662	40.00
43.00	04300	NURSERY	2,001,994		2,001,994	0	2,001,994	43.00
44.00	04400	SKILLED NURSING FACILITY	5,679,874		5,679,874	0	5,679,874	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	29,727,036		29,727,036	0	29,727,036	50.00
51.00	05100	RECOVERY ROOM	1,647,178		1,647,178	0	1,647,178	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,949,998		5,949,998	0	5,949,998	52.00
52.01	05201	PERINATAL CLINIC	2,505,109		2,505,109	0	2,505,109	52.01
53.00	05300	ANESTHESIOLOGY	1,024,676		1,024,676	25,217	1,049,893	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,748,999		11,748,999	0	11,748,999	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,242,082		6,242,082	3,815	6,245,897	55.00
56.00	05600	RADIOISOTOPE	552,566		552,566	0	552,566	56.00
57.00	05700	CT SCAN	2,817,709		2,817,709	0	2,817,709	57.00
58.00	05800	MRI	898,393		898,393	0	898,393	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,731,066		4,731,066	3,014	4,734,080	59.00
60.00	06000	LABORATORY	5,728,727		5,728,727	0	5,728,727	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,817,335		4,817,335	0	4,817,335	62.00
64.00	06400	INTRAVENOUS THERAPY	4,549,951		4,549,951	0	4,549,951	64.00
65.00	06500	RESPIRATORY THERAPY	7,869,968	0	7,869,968	8,272	7,878,240	65.00
66.00	06600	PHYSICAL THERAPY	3,672,129	0	3,672,129	0	3,672,129	66.00
66.01	06601	CLINICAL NUTRITION	847,895	0	847,895	0	847,895	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,980,329	0	1,980,329	0	1,980,329	67.00
68.00	06800	SPEECH PATHOLOGY	609,338	0	609,338	0	609,338	68.00
69.00	06900	ELECTROCARDIOLOGY	6,173,075		6,173,075	35,602	6,208,677	69.00
69.01	06901	CARDIAC REHABILITATION	1,291,920		1,291,920	7,062	1,298,982	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	498,770		498,770	50,111	548,881	70.00
70.01	07001	ELECTROSHOCK THERAPY	286,628		286,628	0	286,628	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,407,996		40,407,996	0	40,407,996	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,751,297		28,751,297	0	28,751,297	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,677,217		68,677,217	0	68,677,217	73.00
74.00	07400	RENAL DIALYSIS	2,678,343		2,678,343	0	2,678,343	74.00
76.00	03330	ENDOSCOPY	2,149,902		2,149,902	0	2,149,902	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	16,228,821		16,228,821	30	16,228,851	90.00
91.00	09100	EMERGENCY	23,479,218		23,479,218	0	23,479,218	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,618,519		7,618,519		7,618,519	92.00
200.00		Subtotal (see instructions)	438,697,476	0	438,697,476	146,535	438,844,011	200.00
201.00		Less Observation Beds	7,618,519		7,618,519		7,618,519	201.00
202.00		Total (see instructions)	431,078,957	0	431,078,957	146,535	431,225,492	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/6/2022 10:06 am

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	207,905,595		207,905,595		30.00
31.00	03100	INTENSIVE CARE UNIT	29,560,970		29,560,970		31.00
40.00	04000	SUBPROVIDER - IPF	8,453,957		8,453,957		40.00
43.00	04300	NURSERY	3,561,166		3,561,166		43.00
44.00	04400	SKILLED NURSING FACILITY	4,248,226		4,248,226		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	65,751,154	90,434,860	156,186,014	0.190331	0.000000
51.00	05100	RECOVERY ROOM	6,047,436	6,116,229	12,163,665	0.135418	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,116,211	2,133,665	10,249,876	0.580495	0.000000
52.01	05201	PERINATAL CLINIC	117,487	5,897,547	6,015,034	0.416475	0.000000
53.00	05300	ANESTHESIOLOGY	16,935,168	23,879,013	40,814,181	0.025106	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,640,198	53,586,982	79,227,180	0.148295	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	1,117,408	50,749,129	51,866,537	0.120349	0.000000
56.00	05600	RADIOISOTOPE	4,349,636	3,201,116	7,550,752	0.073180	0.000000
57.00	05700	CT SCAN	32,379,877	38,593,254	70,973,131	0.039701	0.000000
58.00	05800	MRI	7,154,660	12,869,266	20,023,926	0.044866	0.000000
59.00	05900	CARDIAC CATHETERIZATION	26,188,683	14,032,763	40,221,446	0.117625	0.000000
60.00	06000	LABORATORY	57,454,434	29,149,826	86,604,260	0.066148	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,156,261	1,723,422	7,879,683	0.611362	0.000000
64.00	06400	INTRAVENOUS THERAPY	1,846,968	21,330,529	23,177,497	0.196309	0.000000
65.00	06500	RESPIRATORY THERAPY	29,353,074	6,837,802	36,190,876	0.217457	0.000000
66.00	06600	PHYSICAL THERAPY	7,389,866	1,520,711	8,910,577	0.412109	0.000000
66.01	06601	CLINICAL NUTRITION	0	48,960	48,960	17.318117	0.000000
67.00	06700	OCCUPATIONAL THERAPY	5,853,827	419,530	6,273,357	0.315673	0.000000
68.00	06800	SPEECH PATHOLOGY	2,803,134	209,725	3,012,859	0.202246	0.000000
69.00	06900	ELECTROCARDIOLOGY	27,910,643	45,777,416	73,688,059	0.083773	0.000000
69.01	06901	CARDIAC REHABILITATION	164,307	917,847	1,082,154	1.193841	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	4,855,620	3,883,439	8,739,059	0.057074	0.000000
70.01	07001	ELECTROSHOCK THERAPY	114,044	351,132	465,176	0.616171	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,973,438	13,796,270	28,769,708	1.404533	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,065,443	18,606,280	38,671,723	0.743471	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	77,289,208	268,898,477	346,187,685	0.198381	0.000000
74.00	07400	RENAL DIALYSIS	6,448,933	412,492	6,861,425	0.390348	0.000000
76.00	03330	ENDOSCOPY	3,446,413	12,733,122	16,179,535	0.132878	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	61,932	26,290,001	26,351,933	0.615849	0.000000
91.00	09100	EMERGENCY	47,424,163	77,863,239	125,287,402	0.187403	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,628,697	15,496,082	22,124,779	0.344343	0.000000
200.00		Subtotal (see instructions)	767,768,237	847,760,126	1,615,528,363		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	767,768,237	847,760,126	1,615,528,363		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.190331		50.00
51.00	05100	RECOVERY ROOM	0.135418		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.580495		52.00
52.01	05201	PERINATAL CLINIC	0.416475		52.01
53.00	05300	ANESTHESIOLOGY	0.025724		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148295		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.120422		55.00
56.00	05600	RADIOISOTOPE	0.073180		56.00
57.00	05700	CT SCAN	0.039701		57.00
58.00	05800	MRI	0.044866		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.117700		59.00
60.00	06000	LABORATORY	0.066148		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.611362		62.00
64.00	06400	INTRAVENOUS THERAPY	0.196309		64.00
65.00	06500	RESPIRATORY THERAPY	0.217686		65.00
66.00	06600	PHYSICAL THERAPY	0.412109		66.00
66.01	06601	CLINICAL NUTRITION	17.318117		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.315673		67.00
68.00	06800	SPEECH PATHOLOGY	0.202246		68.00
69.00	06900	ELECTROCARDIOLOGY	0.084256		69.00
69.01	06901	CARDIAC REHABILITATION	1.200367		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.062808		70.00
70.01	07001	ELECTROSHOCK THERAPY	0.616171		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.404533		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.743471		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.198381		73.00
74.00	07400	RENAL DIALYSIS	0.390348		74.00
76.00	03330	ENDOSCOPY	0.132878		76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.615850		90.00
91.00	09100	EMERGENCY	0.187403		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.344343		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: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/6/2022 10:06 am

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	107,838,252		107,838,252	13,412	107,851,664	30.00
31.00	03100	INTENSIVE CARE UNIT	18,821,504		18,821,504	0	18,821,504	31.00
40.00	04000	SUBPROVIDER - IPF	8,193,662		8,193,662	0	8,193,662	40.00
43.00	04300	NURSERY	2,001,994		2,001,994	0	2,001,994	43.00
44.00	04400	SKILLED NURSING FACILITY	5,679,874		5,679,874	0	5,679,874	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	29,727,036		29,727,036	0	29,727,036	50.00
51.00	05100	RECOVERY ROOM	1,647,178		1,647,178	0	1,647,178	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,949,998		5,949,998	0	5,949,998	52.00
52.01	05201	PERINATAL CLINIC	2,505,109		2,505,109	0	2,505,109	52.01
53.00	05300	ANESTHESIOLOGY	1,024,676		1,024,676	25,217	1,049,893	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,748,999		11,748,999	0	11,748,999	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,242,082		6,242,082	3,815	6,245,897	55.00
56.00	05600	RADIOISOTOPE	552,566		552,566	0	552,566	56.00
57.00	05700	CT SCAN	2,817,709		2,817,709	0	2,817,709	57.00
58.00	05800	MRI	898,393		898,393	0	898,393	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,731,066		4,731,066	3,014	4,734,080	59.00
60.00	06000	LABORATORY	5,728,727		5,728,727	0	5,728,727	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,817,335		4,817,335	0	4,817,335	62.00
64.00	06400	INTRAVENOUS THERAPY	4,549,951		4,549,951	0	4,549,951	64.00
65.00	06500	RESPIRATORY THERAPY	7,869,968	0	7,869,968	8,272	7,878,240	65.00
66.00	06600	PHYSICAL THERAPY	3,672,129	0	3,672,129	0	3,672,129	66.00
66.01	06601	CLINICAL NUTRITION	847,895	0	847,895	0	847,895	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,980,329	0	1,980,329	0	1,980,329	67.00
68.00	06800	SPEECH PATHOLOGY	609,338	0	609,338	0	609,338	68.00
69.00	06900	ELECTROCARDIOLOGY	6,173,075		6,173,075	35,602	6,208,677	69.00
69.01	06901	CARDIAC REHABILITATION	1,291,920		1,291,920	7,062	1,298,982	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	498,770		498,770	50,111	548,881	70.00
70.01	07001	ELECTROSHOCK THERAPY	286,628		286,628	0	286,628	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,407,996		40,407,996	0	40,407,996	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,751,297		28,751,297	0	28,751,297	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,677,217		68,677,217	0	68,677,217	73.00
74.00	07400	RENAL DIALYSIS	2,678,343		2,678,343	0	2,678,343	74.00
76.00	03330	ENDOSCOPY	2,149,902		2,149,902	0	2,149,902	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	16,228,821		16,228,821	30	16,228,851	90.00
91.00	09100	EMERGENCY	23,479,218		23,479,218	0	23,479,218	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,618,519		7,618,519		7,618,519	92.00
200.00		Subtotal (see instructions)	438,697,476	0	438,697,476	146,535	438,844,011	200.00
201.00		Less Observation Beds	7,618,519		7,618,519		7,618,519	201.00
202.00		Total (see instructions)	431,078,957	0	431,078,957	146,535	431,225,492	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/6/2022 10:06 am

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	207,905,595		207,905,595			30.00
31.00	03100	INTENSIVE CARE UNIT	29,560,970		29,560,970			31.00
40.00	04000	SUBPROVIDER - IPF	8,453,957		8,453,957			40.00
43.00	04300	NURSERY	3,561,166		3,561,166			43.00
44.00	04400	SKILLED NURSING FACILITY	4,248,226		4,248,226			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	65,751,154	90,434,860	156,186,014	0.190331	0.000000	50.00
51.00	05100	RECOVERY ROOM	6,047,436	6,116,229	12,163,665	0.135418	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,116,211	2,133,665	10,249,876	0.580495	0.000000	52.00
52.01	05201	PERINATAL CLINIC	117,487	5,897,547	6,015,034	0.416475	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	16,935,168	23,879,013	40,814,181	0.025106	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,640,198	53,586,982	79,227,180	0.148295	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,117,408	50,749,129	51,866,537	0.120349	0.000000	55.00
56.00	05600	RADIOISOTOPE	4,349,636	3,201,116	7,550,752	0.073180	0.000000	56.00
57.00	05700	CT SCAN	32,379,877	38,593,254	70,973,131	0.039701	0.000000	57.00
58.00	05800	MRI	7,154,660	12,869,266	20,023,926	0.044866	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	26,188,683	14,032,763	40,221,446	0.117625	0.000000	59.00
60.00	06000	LABORATORY	57,454,434	29,149,826	86,604,260	0.066148	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,156,261	1,723,422	7,879,683	0.611362	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	1,846,968	21,330,529	23,177,497	0.196309	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	29,353,074	6,837,802	36,190,876	0.217457	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,389,866	1,520,711	8,910,577	0.412109	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	48,960	48,960	17.318117	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	5,853,827	419,530	6,273,357	0.315673	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,803,134	209,725	3,012,859	0.202246	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	27,910,643	45,777,416	73,688,059	0.083773	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	164,307	917,847	1,082,154	1.193841	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	4,855,620	3,883,439	8,739,059	0.057074	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY	114,044	351,132	465,176	0.616171	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,973,438	13,796,270	28,769,708	1.404533	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,065,443	18,606,280	38,671,723	0.743471	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,289,208	268,898,477	346,187,685	0.198381	0.000000	73.00
74.00	07400	RENAL DIALYSIS	6,448,933	412,492	6,861,425	0.390348	0.000000	74.00
76.00	03330	ENDOSCOPY	3,446,413	12,733,122	16,179,535	0.132878	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	61,932	26,290,001	26,351,933	0.615849	0.000000	90.00
91.00	09100	EMERGENCY	47,424,163	77,863,239	125,287,402	0.187403	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,628,697	15,496,082	22,124,779	0.344343	0.000000	92.00
200.00		Subtotal (see instructions)	767,768,237	847,760,126	1,615,528,363			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	767,768,237	847,760,126	1,615,528,363			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
52.01	05201	PERINATAL CLINIC	0.000000		52.01
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
66.01	06601	CLINICAL NUTRITION	0.000000		66.01
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
69.01	06901	CARDIAC REHABILITATION	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001	ELECTROSHOCK THERAPY	0.000000		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03330	ENDOSCOPY	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
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: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
7/6/2022 10:06 am

			Title XVIII		Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	6,081,769	0	6,081,769	99,407	61.18	30.00	
31.00	INTENSIVE CARE UNIT	868,087		868,087	7,774	111.67	31.00	
40.00	SUBPROVIDER - IPF	1,066,777	0	1,066,777	4,220	252.79	40.00	
43.00	NURSERY	244,233		244,233	2,404	101.59	43.00	
44.00	SKILLED NURSING FACILITY	192,691		192,691	16,810	11.46	44.00	
200.00	Total (lines 30 through 199)	8,453,557		8,453,557	130,615		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	19,752	1,208,427					30.00
31.00	INTENSIVE CARE UNIT	2,166	241,877					31.00
40.00	SUBPROVIDER - IPF	1,555	393,088					40.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	4,366	50,034					44.00
200.00	Total (lines 30 through 199)	27,839	1,893,426					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description		Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Program Charges	Capital Costs (column 3 x column 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,313,117	156,186,014	0.021213	21,091,560	447,415	50.00
51.00	05100 RECOVERY ROOM	18,706	12,163,665	0.001538	2,455,882	3,777	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,065,638	10,249,876	0.103966	25,600	2,662	52.00
52.01	05201 PERINATAL CLINIC	627,415	6,015,034	0.104308	0	0	52.01
53.00	05300 ANESTHESIOLOGY	154,324	40,814,181	0.003781	3,622,506	13,697	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	781,462	79,227,180	0.009864	5,151,379	50,813	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	1,107,272	51,866,537	0.021348	279,059	5,957	55.00
56.00	05600 RADIOISOTOPE	51,703	7,550,752	0.006847	1,275,383	8,733	56.00
57.00	05700 CT SCAN	392,689	70,973,131	0.005533	8,612,337	47,652	57.00
58.00	05800 MRI	93,943	20,023,926	0.004692	1,904,700	8,937	58.00
59.00	05900 CARDIAC CATHETERIZATION	282,227	40,221,446	0.007017	4,375,040	30,700	59.00
60.00	06000 LABORATORY	804,400	86,604,260	0.009288	16,340,421	151,770	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	118,955	7,879,683	0.015096	1,777,687	26,836	62.00
64.00	06400 INTRAVENOUS THERAPY	452,815	23,177,497	0.019537	10,293	201	64.00
65.00	06500 RESPIRATORY THERAPY	435,629	36,190,876	0.012037	5,813,915	69,982	65.00
66.00	06600 PHYSICAL THERAPY	272,864	8,910,577	0.030622	1,765,060	54,050	66.00
66.01	06601 CLINICAL NUTRITION	9,206	48,960	0.188031	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	145,995	6,273,357	0.023272	1,265,118	29,442	67.00
68.00	06800 SPEECH PATHOLOGY	8,896	3,012,859	0.002953	887,216	2,620	68.00
69.00	06900 ELECTROCARDIOLOGY	453,165	73,688,059	0.006150	7,244,121	44,551	69.00
69.01	06901 CARDIAC REHABILITATION	296,663	1,082,154	0.274141	23,667	6,488	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	26,418	8,739,059	0.003023	1,423,652	4,304	70.00
70.01	07001 ELECTROSHOCK THERAPY	49,043	465,176	0.105429	3,000	316	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	787,602	28,769,708	0.027376	3,538,360	96,866	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	541,145	38,671,723	0.013993	5,658,530	79,180	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,363,894	346,187,685	0.003940	18,037,972	71,070	73.00
74.00	07400 RENAL DIALYSIS	69,742	6,861,425	0.010164	2,874,066	29,212	74.00
76.00	03330 ENDOSCOPY	175,454	16,179,535	0.010844	782,075	8,481	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,893,373	26,351,933	0.071849	2,689	193	90.00
91.00	09100 EMERGENCY	1,204,780	125,287,402	0.009616	11,627,045	111,806	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	429,608	22,124,779	0.019418	3,490,005	67,769	92.00
200.00	Total (lines 50 through 199)	17,428,143	1,361,798,449		131,358,338	1,475,480	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part III
Date/Time Prepared:
7/6/2022 10:06 am

				Title XVIII		Hospital		PPS	
Cost Center Description				Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
				1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	149,804	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	99,870	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	24,967	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	274,641	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	149,804	99,407	1.51	19,752	30.00	
31.00	03100	INTENSIVE CARE UNIT		99,870	7,774	12.85	2,166	31.00	
40.00	04000	SUBPROVIDER - IPF	0	24,967	4,220	5.92	1,555	40.00	
43.00	04300	NURSERY		0	2,404	0.00	0	43.00	
44.00	04400	SKILLED NURSING FACILITY		0	16,810	0.00	4,366	44.00	
200.00		Total (lines 30 through 199)		274,641	130,615		27,839	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	29,826						30.00
31.00	03100	INTENSIVE CARE UNIT	27,833						31.00
40.00	04000	SUBPROVIDER - IPF	9,206						40.00
43.00	04300	NURSERY	0						43.00
44.00	04400	SKILLED NURSING FACILITY	0						44.00
200.00		Total (lines 30 through 199)	66,865						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description			Title XVIII		Hospital		PPS
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
52.01	05201	PERINATAL CLINIC	0	0	0	0	0 52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0 62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	0 66.01
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	99,870 69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	0	0 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.00	03330	ENDOSCOPY	0	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	0	0	0	74,902 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	10,582 92.00
200.00		Total (lines 50 through 199)	0	0	0	0	185,354 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description			Title XVIII		Hospital		PPS	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	156,186,014	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	12,163,665	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,249,876	0.000000	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	6,015,034	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	40,814,181	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	79,227,180	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	51,866,537	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	7,550,752	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	70,973,131	0.000000	57.00
58.00	05800	MRI	0	0	0	20,023,926	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	40,221,446	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	86,604,260	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	7,879,683	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	23,177,497	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	36,190,876	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,910,577	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	48,960	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,273,357	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,012,859	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	99,870	99,870	73,688,059	0.001355	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	1,082,154	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	8,739,059	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	465,176	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	28,769,708	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	38,671,723	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	346,187,685	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	6,861,425	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	16,179,535	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	26,351,933	0.000000	90.00
91.00	09100	EMERGENCY	0	74,902	74,902	125,287,402	0.000598	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,582	10,582	22,124,779	0.000478	92.00
200.00		Total (lines 50 through 199)	0	185,354	185,354	1,361,798,449		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
7/6/2022 10:06 am

				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	21,091,560	0	30,762,897	0
51.00	05100	RECOVERY ROOM		0.000000	2,455,882	0	4,869,920	0
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	25,600	0	2,460	0
52.01	05201	PERINATAL CLINIC		0.000000	0	0	0	0
53.00	05300	ANESTHESIOLOGY		0.000000	3,622,506	0	2,984,750	0
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	5,151,379	0	6,229,630	0
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	279,059	0	13,482,867	0
56.00	05600	RADIOISOTOPE		0.000000	1,275,383	0	1,262,352	0
57.00	05700	CT SCAN		0.000000	8,612,337	0	6,190,280	0
58.00	05800	MRI		0.000000	1,904,700	0	2,770,900	0
59.00	05900	CARDIAC CATHETERIZATION		0.000000	4,375,040	0	1,984,320	0
60.00	06000	LABORATORY		0.000000	16,340,421	0	5,111,936	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0.000000	1,777,687	0	101,650	0
64.00	06400	INTRAVENOUS THERAPY		0.000000	10,293	0	1,302,800	0
65.00	06500	RESPIRATORY THERAPY		0.000000	5,813,915	0	816,806	0
66.00	06600	PHYSICAL THERAPY		0.000000	1,765,060	0	158,076	0
66.01	06601	CLINICAL NUTRITION		0.000000	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY		0.000000	1,265,118	0	12,610	0
68.00	06800	SPEECH PATHOLOGY		0.000000	887,216	0	25,962	0
69.00	06900	ELECTROCARDIOLOGY		0.001355	7,244,121	9,816	4,430,466	6,003
69.01	06901	CARDIAC REHABILITATION		0.000000	23,667	0	280,410	0
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	1,423,652	0	631,418	0
70.01	07001	ELECTROSHOCK THERAPY		0.000000	3,000	0	10,500	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	3,538,360	0	3,048,599	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	5,658,530	0	3,689,731	0
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	18,037,972	0	78,388,100	0
74.00	07400	RENAL DIALYSIS		0.000000	2,874,066	0	149,900	0
76.00	03330	ENDOSCOPY		0.000000	782,075	0	1,420,567	0
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC		0.000000	2,689	0	6,097,918	0
91.00	09100	EMERGENCY		0.000598	11,627,045	6,953	7,290,684	4,360
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000478	3,490,005	1,668	3,187,638	1,524
200.00		Total (lines 50 through 199)			131,358,338	18,437	186,696,147	11,887

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
7/6/2022 10:06 am

			Title XVIII		Hospital		PPS		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.190331	30,762,897	0	0	5,855,133	50.00	
51.00	05100	RECOVERY ROOM	0.135418	4,869,920	0	0	659,475	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.580495	2,460	0	0	1,428	52.00	
52.01	05201	PERINATAL CLINIC	0.416475	0	0	0	0	52.01	
53.00	05300	ANESTHESIOLOGY	0.025106	2,984,750	0	0	74,935	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148295	6,229,630	0	0	923,823	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.120349	13,482,867	0	0	1,622,650	55.00	
56.00	05600	RADIOISOTOPE	0.073180	1,262,352	0	0	92,379	56.00	
57.00	05700	CT SCAN	0.039701	6,190,280	0	0	245,760	57.00	
58.00	05800	MRI	0.044866	2,770,900	0	0	124,319	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.117625	1,984,320	0	0	233,406	59.00	
60.00	06000	LABORATORY	0.066148	5,111,936	0	0	338,144	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.611362	101,650	0	0	62,145	62.00	
64.00	06400	INTRAVENOUS THERAPY	0.196309	1,302,800	0	0	255,751	64.00	
65.00	06500	RESPIRATORY THERAPY	0.217457	816,806	0	0	177,620	65.00	
66.00	06600	PHYSICAL THERAPY	0.412109	158,076	0	0	65,145	66.00	
66.01	06601	CLINICAL NUTRITION	17.318117	0	0	0	0	66.01	
67.00	06700	OCCUPATIONAL THERAPY	0.315673	12,610	0	0	3,981	67.00	
68.00	06800	SPEECH PATHOLOGY	0.202246	25,962	0	0	5,251	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.083773	4,430,466	0	0	371,153	69.00	
69.01	06901	CARDIAC REHABILITATION	1.193841	280,410	0	0	334,765	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.057074	631,418	0	0	36,038	70.00	
70.01	07001	ELECTROSHOCK THERAPY	0.616171	10,500	0	0	6,470	70.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.404533	3,048,599	0	0	4,281,858	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.743471	3,689,731	0	0	2,743,208	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.198381	78,388,100	484	125,769	15,550,710	73.00	
74.00	07400	RENAL DIALYSIS	0.390348	149,900	0	0	58,513	74.00	
76.00	03330	ENDOSCOPY	0.132878	1,420,567	0	0	188,762	76.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.615849	6,097,918	0	960	3,755,397	90.00	
91.00	09100	EMERGENCY	0.187403	7,290,684	0	0	1,366,296	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.344343	3,187,638	0	0	1,097,641	92.00	
200.00		Subtotal (see instructions)		186,696,147	484	126,729	40,532,156	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		186,696,147	484	126,729	40,532,156	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
7/6/2022 10:06 am

			Title XVIII		Hospital	PPS
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
52.01	05201	PERINATAL CLINIC	0	0		52.01
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
66.01	06601	CLINICAL NUTRITION	0	0		66.01
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
69.01	06901	CARDIAC REHABILITATION	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	96	24,950		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03330	ENDOSCOPY	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	591		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	96	25,541		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	96	25,541		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-0104

Period:

Worksheet D

Component CCN: 26-S104

From 01/01/2021

Part II

To 12/31/2021

Date/Time Prepared:

7/6/2022 10:06 am

Title XVIII

Subprovider -
IPF

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	3,313,117	156,186,014	0.021213	0	0	50.00
51.00	05100	RECOVERY ROOM	18,706	12,163,665	0.001538	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,065,638	10,249,876	0.103966	0	0	52.00
52.01	05201	PERINATAL CLINIC	627,415	6,015,034	0.104308	0	0	52.01
53.00	05300	ANESTHESIOLOGY	154,324	40,814,181	0.003781	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	781,462	79,227,180	0.009864	6,584	65	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,107,272	51,866,537	0.021348	120	3	55.00
56.00	05600	RADIOISOTOPE	51,703	7,550,752	0.006847	4,170	29	56.00
57.00	05700	CT SCAN	392,689	70,973,131	0.005533	12,800	71	57.00
58.00	05800	MRI	93,943	20,023,926	0.004692	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	282,227	40,221,446	0.007017	0	0	59.00
60.00	06000	LABORATORY	804,400	86,604,260	0.009288	191,460	1,778	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	118,955	7,879,683	0.015096	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	452,815	23,177,497	0.019537	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	435,629	36,190,876	0.012037	2,240	27	65.00
66.00	06600	PHYSICAL THERAPY	272,864	8,910,577	0.030622	380	12	66.00
66.01	06601	CLINICAL NUTRITION	9,206	48,960	0.188031	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	145,995	6,273,357	0.023272	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,896	3,012,859	0.002953	290	1	68.00
69.00	06900	ELECTROCARDIOLOGY	453,165	73,688,059	0.006150	8,500	52	69.00
69.01	06901	CARDIAC REHABILITATION	296,663	1,082,154	0.274141	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	26,418	8,739,059	0.003023	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	49,043	465,176	0.105429	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	787,602	28,769,708	0.027376	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	541,145	38,671,723	0.013993	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,363,894	346,187,685	0.003940	327,931	1,292	73.00
74.00	07400	RENAL DIALYSIS	69,742	6,861,425	0.010164	4,200	43	74.00
76.00	03330	ENDOSCOPY	175,454	16,179,535	0.010844	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,893,373	26,351,933	0.071849	0	0	90.00
91.00	09100	EMERGENCY	1,204,780	125,287,402	0.009616	189,880	1,826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	22,124,779	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	16,998,535	1,361,798,449		748,555	5,199	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-S104		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/6/2022 10:06 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC		0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION		0	0	0	0	0	66.01
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	99,870	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY		0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY		0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	74,902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	174,772	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-S104		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/6/2022 10:06 am	
				Title XVIII		Subprovider - IPF		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	156,186,014	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	12,163,665	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	10,249,876	0.000000	52.00
52.01	05201	PERINATAL CLINIC		0	0	0	6,015,034	0.000000	52.01
53.00	05300	ANESTHESIOLOGY		0	0	0	40,814,181	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	79,227,180	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	51,866,537	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	7,550,752	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	70,973,131	0.000000	57.00
58.00	05800	MRI		0	0	0	20,023,926	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	40,221,446	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	86,604,260	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	7,879,683	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	23,177,497	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	36,190,876	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	8,910,577	0.000000	66.00
66.01	06601	CLINICAL NUTRITION		0	0	0	48,960	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	6,273,357	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	3,012,859	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	99,870	99,870	73,688,059	0.001355	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	1,082,154	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	8,739,059	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY		0	0	0	465,176	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	28,769,708	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	38,671,723	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	346,187,685	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	6,861,425	0.000000	74.00
76.00	03330	ENDOSCOPY		0	0	0	16,179,535	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	26,351,933	0.000000	90.00
91.00	09100	EMERGENCY		0	74,902	74,902	125,287,402	0.000598	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	22,124,779	0.000000	92.00
200.00		Total (lines 50 through 199)		0	174,772	174,772	1,361,798,449		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-S104		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/6/2022 10:06 am	
				Title XVIII		Subprovider - IPF		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	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.000000	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	6,584	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	120	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	4,170	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	12,800	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	191,460	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,240	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	380	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	290	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001355	8,500	12	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.000000	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	327,931	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	4,200	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.000000	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000598	189,880	114	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		748,555	126	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
7/6/2022 10:06 am

			Title XIX		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)		PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.190331	4,214,996	0	0	802,244	50.00
51.00	05100	RECOVERY ROOM	0.135418	403,335	0	0	54,619	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.580495	50,840	0	0	29,512	52.00
52.01	05201	PERINATAL CLINIC	0.416475	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.025106	565,494	0	0	14,197	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148295	1,855,414	0	0	275,149	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.120349	3,314,390	0	0	398,884	55.00
56.00	05600	RADIOISOTOPE	0.073180	203,600	0	0	14,899	56.00
57.00	05700	CT SCAN	0.039701	2,963,064	0	0	117,637	57.00
58.00	05800	MRI	0.044866	660,400	0	0	29,630	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.117625	514,100	0	0	60,471	59.00
60.00	06000	LABORATORY	0.066148	2,783,921	0	0	184,151	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.611362	69,990	0	0	42,789	62.00
64.00	06400	INTRAVENOUS THERAPY	0.196309	115,670	0	0	22,707	64.00
65.00	06500	RESPIRATORY THERAPY	0.217457	166,140	0	0	36,128	65.00
66.00	06600	PHYSICAL THERAPY	0.412109	35,305	0	0	14,550	66.00
66.01	06601	CLINICAL NUTRITION	17.318117	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.315673	15,746	0	0	4,971	67.00
68.00	06800	SPEECH PATHOLOGY	0.202246	11,730	0	0	2,372	68.00
69.00	06900	ELECTROCARDIOLOGY	0.083773	980,372	0	0	82,129	69.00
69.01	06901	CARDIAC REHABILITATION	1.193841	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.057074	248,878	0	0	14,204	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.616171	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.404533	551,711	0	0	774,896	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.743471	559,630	0	0	416,069	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.198381	186,797	0	0	37,057	73.00
74.00	07400	RENAL DIALYSIS	0.390348	41,435	0	0	16,174	74.00
76.00	03330	ENDOSCOPY	0.132878	225,800	0	0	30,004	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.615849	1,990,478	0	0	1,225,834	90.00
91.00	09100	EMERGENCY	0.187403	6,938,900	0	0	1,300,371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.344343	7,201	0	0	2,480	92.00
200.00		Subtotal (see instructions)		29,675,337	0	0	6,004,128	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		29,675,337	0	0	6,004,128	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
7/6/2022 10:06 am

			Title XIX		Hospital	Cost
Cost Center Description	Costs					
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
52.01	05201	PERINATAL CLINIC	0	0		52.01
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
66.01	06601	CLINICAL NUTRITION	0	0		66.01
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
69.01	06901	CARDIAC REHABILITATION	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03330	ENDOSCOPY	0	0		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-5842		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/6/2022 10:06 am	
				Title XIX		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC		0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION		0	0	0	0	0	66.01
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	99,870	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY		0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY		0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	74,902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	174,772	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-5842		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/6/2022 10:06 am	
				Title XIX		Skilled Nursing Facility		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	156,186,014	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	12,163,665	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	10,249,876	0.000000	52.00
52.01	05201	PERINATAL CLINIC		0	0	0	6,015,034	0.000000	52.01
53.00	05300	ANESTHESIOLOGY		0	0	0	40,814,181	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	79,227,180	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	51,866,537	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	7,550,752	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	70,973,131	0.000000	57.00
58.00	05800	MRI		0	0	0	20,023,926	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	40,221,446	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	86,604,260	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	7,879,683	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	23,177,497	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	36,190,876	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	8,910,577	0.000000	66.00
66.01	06601	CLINICAL NUTRITION		0	0	0	48,960	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	6,273,357	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	3,012,859	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	99,870	99,870	73,688,059	0.001355	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	1,082,154	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	8,739,059	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY		0	0	0	465,176	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	28,769,708	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	38,671,723	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	346,187,685	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	6,861,425	0.000000	74.00
76.00	03330	ENDOSCOPY		0	0	0	16,179,535	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	26,351,933	0.000000	90.00
91.00	09100	EMERGENCY		0	74,902	74,902	125,287,402	0.000598	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	22,124,779	0.000000	92.00
200.00		Total (lines 50 through 199)		0	174,772	174,772	1,361,798,449		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-5842		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/6/2022 10:06 am	
				Title XIX		Skilled Nursing Facility		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	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.000000	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001355	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.000000	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.000000	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000598	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/6/2022 10:06 am
		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)		99,407	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		99,407	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)		92,385	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)		19,752	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)		107,851,664	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)		107,851,664	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)		107,851,664	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)		1,084.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		21,429,932	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)		21,429,932	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0104

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

Worksheet D-1

Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		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	18,821,504	7,774	2,421.08	2,166	5,244,059	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					29,122,983	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					55,796,974	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,507,963	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,493,917	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					3,001,880	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					52,795,094	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)					7,022	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,084.95	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					7,618,519	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0104

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

Worksheet D-1

Date/Time Prepared:
7/6/2022 10:06 am

		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	6,081,769	107,851,664	0.056390	7,618,519	429,608	90.00
91.00 Nursing Program cost	0	107,851,664	0.000000	7,618,519	0	91.00
92.00 Allied health cost	149,804	107,851,664	0.001389	7,618,519	10,582	92.00
93.00 All other Medical Education	0	107,851,664	0.000000	7,618,519	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0104 Component CCN: 26-S104	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/6/2022 10:06 am
		Title XVIII	Subprovider - IPF	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)		4,220	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,220	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)		4,220	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,555	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)		8,193,662	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)		8,193,662	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)		8,193,662	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)		1,941.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,019,235	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,019,235	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1		
				Component CCN: 26-S104		Date/Time Prepared: 7/6/2022 10:06 am		
				Title XVIII		Subprovider - IPF	PPS	
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
			1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)		0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT		0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description								
							1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						118,166	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						3,137,401	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)						402,294	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						5,325	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						407,619	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						2,729,782	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0104 Component CCN: 26-S104		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 7/6/2022 10:06 am	
		Title XVIII		Subprovider - IPF		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	1,066,777	8,193,662	0.130195	0	0	90.00
91.00	Nursing Program cost	0	8,193,662	0.000000	0	0	91.00
92.00	Allied health cost	24,967	8,193,662	0.003047	0	0	92.00
93.00	All other Medical Education	0	8,193,662	0.000000	0	0	93.00

Health Financial Systems		SSM HEALTH DEPAUL HOSPITAL		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1	
		Component CCN: 26-5842		Date/Time Prepared: 7/6/2022 10:06 am	
		Title XVIII	Skilled Nursing Facility	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)		16,810	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,810	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)		16,810	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)		4,366	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)		5,679,874	21.00	
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00	
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00	
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00	
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00	
26.00	Total swing-bed cost (see instructions)		0	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,679,874	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)		5,679,874	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)			38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00	

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1
				Component CCN: 26-5842		Date/Time Prepared: 7/6/2022 10:06 am
				Title XVIII	Skilled Nursing Facility	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)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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)						50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges						54.00
55.00 Target amount per discharge						55.00
56.00 Target amount (line 54 x line 55)						56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00 Bonus payment (see instructions)						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						59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00 Relief payment (see instructions)						62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)					5,679,874	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					337.89	71.00
72.00 Program routine service cost (line 9 x line 71)					1,475,228	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					1,475,228	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)					0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00 Inpatient routine service cost per diem limitation					0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)					1,475,228	83.00
84.00 Program inpatient ancillary services (see instructions)					505,444	84.00
85.00 Utilization review - physician compensation (see instructions)					0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					1,980,672	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 26-0104 Component CCN: 26-5842		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 7/6/2022 10:06 am
			Title XVIII		Skilled Nursing Facility		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	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0104 Component CCN: 26-5842	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/6/2022 10:06 am
		Title XIX	Skilled Nursing Facility	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)		16,810	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,810	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)		16,810	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)		11,209	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)		2,404	15.00
16.00	Nursery days (title V or XIX only)		217	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)		5,679,874	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,679,874	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)		5,679,874	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1
				Component CCN: 26-5842		Date/Time Prepared: 7/6/2022 10:06 am
				Title XIX	Skilled Nursing Facility	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)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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)						50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges						54.00
55.00 Target amount per discharge						55.00
56.00 Target amount (line 54 x line 55)						56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00 Bonus payment (see instructions)						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						59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00 Relief payment (see instructions)						62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)					5,679,874	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					337.89	71.00
72.00 Program routine service cost (line 9 x line 71)					3,787,409	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					3,787,409	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					192,691	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					11.46	76.00
77.00 Program capital-related costs (line 9 x line 76)					128,455	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					3,658,954	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					3,658,954	80.00
81.00 Inpatient routine service cost per diem limitation					0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)					128,455	83.00
84.00 Program inpatient ancillary services (see instructions)					0	84.00
85.00 Utilization review - physician compensation (see instructions)					0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					128,455	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0104

Period:

Worksheet D-1

Component CCN: 26-5842

From 01/01/2021
To 12/31/2021Date/Time Prepared:
7/6/2022 10:06 am

Title XIX

Skilled Nursing
Facility

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	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 7/6/2022 10:06 am	
Cost Center Description			Title XVIII	Hospital	PPS	
			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		39,852,472		30.00
31.00	03100	INTENSIVE CARE UNIT		7,357,400		31.00
40.00	04000	SUBPROVIDER - IPF		2,340		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.190331	21,091,560	4,014,378	50.00
51.00	05100	RECOVERY ROOM	0.135418	2,455,882	332,571	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.580495	25,600	14,861	52.00
52.01	05201	PERINATAL CLINIC	0.416475	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.025724	3,622,506	93,185	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148295	5,151,379	763,924	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.120422	279,059	33,605	55.00
56.00	05600	RADIOISOTOPE	0.073180	1,275,383	93,333	56.00
57.00	05700	CT SCAN	0.039701	8,612,337	341,918	57.00
58.00	05800	MRI	0.044866	1,904,700	85,456	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.117700	4,375,040	514,942	59.00
60.00	06000	LABORATORY	0.066148	16,340,421	1,080,886	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.611362	1,777,687	1,086,810	62.00
64.00	06400	INTRAVENOUS THERAPY	0.196309	10,293	2,021	64.00
65.00	06500	RESPIRATORY THERAPY	0.217686	5,813,915	1,265,608	65.00
66.00	06600	PHYSICAL THERAPY	0.412109	1,765,060	727,397	66.00
66.01	06601	CLINICAL NUTRITION	17.318117	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.315673	1,265,118	399,364	67.00
68.00	06800	SPEECH PATHOLOGY	0.202246	887,216	179,436	68.00
69.00	06900	ELECTROCARDIOLOGY	0.084256	7,244,121	610,361	69.00
69.01	06901	CARDIAC REHABILITATION	1.200367	23,667	28,409	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.062808	1,423,652	89,417	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.616171	3,000	1,849	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.404533	3,538,360	4,969,743	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.743471	5,658,530	4,206,953	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.198381	18,037,972	3,578,391	73.00
74.00	07400	RENAL DIALYSIS	0.390348	2,874,066	1,121,886	74.00
76.00	03330	ENDOSCOPY	0.132878	782,075	103,921	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.615850	2,689	1,656	90.00
91.00	09100	EMERGENCY	0.187403	11,627,045	2,178,943	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.344343	3,490,005	1,201,759	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		131,358,338	29,122,983	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		131,358,338		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 7/6/2022 10:06 am	
		Component CCN: 26-S104			
		Title XVIII	Subprovider - IPF	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				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF		2,797,254		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.190331	0	0	50.00
51.00	05100 RECOVERY ROOM	0.135418	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.580495	0	0	52.00
52.01	05201 PERINATAL CLINIC	0.416475	0	0	52.01
53.00	05300 ANESTHESIOLOGY	0.025724	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.148295	6,584	976	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.120422	120	14	55.00
56.00	05600 RADIOISOTOPE	0.073180	4,170	305	56.00
57.00	05700 CT SCAN	0.039701	12,800	508	57.00
58.00	05800 MRI	0.044866	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.117700	0	0	59.00
60.00	06000 LABORATORY	0.066148	191,460	12,665	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.611362	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0.196309	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.217686	2,240	488	65.00
66.00	06600 PHYSICAL THERAPY	0.412109	380	157	66.00
66.01	06601 CLINICAL NUTRITION	17.318117	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.315673	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.202246	290	59	68.00
69.00	06900 ELECTROCARDIOLOGY	0.084256	8,500	716	69.00
69.01	06901 CARDIAC REHABILITATION	1.200367	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.062808	0	0	70.00
70.01	07001 ELECTROSHOCK THERAPY	0.616171	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.404533	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.743471	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.198381	327,931	65,055	73.00
74.00	07400 RENAL DIALYSIS	0.390348	4,200	1,639	74.00
76.00	03330 ENDOSCOPY	0.132878	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.615850	0	0	90.00
91.00	09100 EMERGENCY	0.187403	189,880	35,584	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.344343	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		748,555	118,166	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		748,555		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3	
		Component CCN: 26-5842		Date/Time Prepared: 7/6/2022 10:06 am	
		Title XVIII	Skilled Nursing Facility	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				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.190331	0	0	50.00
51.00	05100 RECOVERY ROOM	0.135418	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.580495	0	0	52.00
52.01	05201 PERINATAL CLINIC	0.416475	0	0	52.01
53.00	05300 ANESTHESIOLOGY	0.025724	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.148295	6,631	983	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.120422	0	0	55.00
56.00	05600 RADIOISOTOPE	0.073180	0	0	56.00
57.00	05700 CT SCAN	0.039701	0	0	57.00
58.00	05800 MRI	0.044866	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.117700	0	0	59.00
60.00	06000 LABORATORY	0.066148	6,190	409	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.611362	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0.196309	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.217686	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.412109	622,450	256,517	66.00
66.01	06601 CLINICAL NUTRITION	17.318117	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.315673	596,550	188,315	67.00
68.00	06800 SPEECH PATHOLOGY	0.202246	176,400	35,676	68.00
69.00	06900 ELECTROCARDIOLOGY	0.084256	0	0	69.00
69.01	06901 CARDIAC REHABILITATION	1.200367	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.062808	0	0	70.00
70.01	07001 ELECTROSHOCK THERAPY	0.616171	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.404533	717	1,007	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.743471	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.198381	113,607	22,537	73.00
74.00	07400 RENAL DIALYSIS	0.390348	0	0	74.00
76.00	03330 ENDOSCOPY	0.132878	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.615850	0	0	90.00
91.00	09100 EMERGENCY	0.187403	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.344343	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,522,545	505,444	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,522,545		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 7/6/2022 10:06 am	
Cost Center Description			Title XIX	Hospital	Cost	
			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		26,023,979		30.00
31.00	03100	INTENSIVE CARE UNIT		3,340,168		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		281,968		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.190331	5,467,546	1,040,643	50.00
51.00	05100	RECOVERY ROOM	0.135418	611,268	82,777	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.580495	83,220	48,309	52.00
52.01	05201	PERINATAL CLINIC	0.416475	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.025106	961,135	24,130	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148295	1,612,143	239,073	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.120349	238,880	28,749	55.00
56.00	05600	RADIOISOTOPE	0.073180	316,910	23,191	56.00
57.00	05700	CT SCAN	0.039701	3,084,747	122,468	57.00
58.00	05800	MRI	0.044866	781,650	35,070	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.117625	1,263,802	148,655	59.00
60.00	06000	LABORATORY	0.066148	7,662,861	506,883	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.611362	450,666	275,520	62.00
64.00	06400	INTRAVENOUS THERAPY	0.196309	31,268	6,138	64.00
65.00	06500	RESPIRATORY THERAPY	0.217457	2,797,198	608,270	65.00
66.00	06600	PHYSICAL THERAPY	0.412109	424,199	174,816	66.00
66.01	06601	CLINICAL NUTRITION	17.318117	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.315673	343,937	108,572	67.00
68.00	06800	SPEECH PATHOLOGY	0.202246	242,915	49,129	68.00
69.00	06900	ELECTROCARDIOLOGY	0.083773	2,019,022	169,140	69.00
69.01	06901	CARDIAC REHABILITATION	1.193841	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.057074	610,774	34,859	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.616171	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.404533	1,024,420	1,438,832	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.743471	890,669	662,187	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.198381	24,351,324	4,830,840	73.00
74.00	07400	RENAL DIALYSIS	0.390348	412,872	161,164	74.00
76.00	03330	ENDOSCOPY	0.132878	218,795	29,073	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.615849	0	0	90.00
91.00	09100	EMERGENCY	0.187403	6,170,652	1,156,399	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.344343	2,169,405	747,019	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		64,242,278	12,751,906	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		64,242,278	12,751,906	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 7/6/2022 10:06 am	
		Component CCN: 26-S104			
		Title XIX	Subprovider - IPF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF		4,271,861		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.190331	0	0	50.00
51.00	05100 RECOVERY ROOM	0.135418	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.580495	0	0	52.00
52.01	05201 PERINATAL CLINIC	0.416475	0	0	52.01
53.00	05300 ANESTHESIOLOGY	0.025106	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.148295	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.120349	0	0	55.00
56.00	05600 RADIOISOTOPE	0.073180	0	0	56.00
57.00	05700 CT SCAN	0.039701	0	0	57.00
58.00	05800 MRI	0.044866	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.117625	0	0	59.00
60.00	06000 LABORATORY	0.066148	220	15	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.611362	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0.196309	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.217457	160	35	65.00
66.00	06600 PHYSICAL THERAPY	0.412109	0	0	66.00
66.01	06601 CLINICAL NUTRITION	17.318117	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.315673	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.202246	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.083773	0	0	69.00
69.01	06901 CARDIAC REHABILITATION	1.193841	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.057074	0	0	70.00
70.01	07001 ELECTROSHOCK THERAPY	0.616171	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.404533	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.743471	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.198381	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.390348	0	0	74.00
76.00	03330 ENDOSCOPY	0.132878	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.615849	2,850	1,755	90.00
91.00	09100 EMERGENCY	0.187403	1,140	214	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.344343	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		4,370	2,019	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		4,370	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 7/6/2022 10:06 am
		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)		32,810,383	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		10,810,382	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)		933,421	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		312,094	2.04
3.00	Managed Care Simulated Payments		54,857,110	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		400.76	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.		14.25	11.00
12.00	Current year allowable FTE (see instructions)		14.25	12.00
13.00	Total allowable FTE count for the prior year.		14.53	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.		14.01	14.00
15.00	Sum of lines 12 through 14 divided by 3.		14.26	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		14.26	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.035582	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.035041	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.035041	21.00
22.00	IME payment adjustment (see instructions)		827,137	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		1,040,201	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)		827,137	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		1,040,201	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.81	30.00
31.00	Percentage of Medicaid patient days (see instructions)		27.31	31.00
32.00	Sum of lines 30 and 31		33.12	32.00
33.00	Allowable disproportionate share percentage (see instructions)		16.54	33.00
34.00	Disproportionate share adjustment (see instructions)		1,803,718	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 7/6/2022 10:06 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		8,290,014,521	7,192,008,710
35.01	Factor 3 (see instructions)		0.000812998	0.000759791
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		6,739,761	5,464,424
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		5,040,971	1,377,335
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		6,418,306	
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges (see instructions)		0	
41.00	Total ESRD Medicare discharges (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	
43.00	Total Medicare ESRD inpatient days (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)		53,915,441	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0	
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		54,955,642	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,648,157	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).		552,467	52.00
53.00	Nursing and Allied Health Managed Care payment		65,631	53.00
54.00	Special add-on payments for new technologies		59,156	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		57,659	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		18,437	58.00
59.00	Total (sum of amounts on lines 49 through 58)		59,357,149	59.00
60.00	Primary payer payments		57,895	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		59,299,254	61.00
62.00	Deductibles billed to program beneficiaries		3,837,288	62.00
63.00	Coinsurance billed to program beneficiaries		372,827	63.00
64.00	Allowable bad debts (see instructions)		1,848,495	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		1,201,522	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,437,274	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		56,290,661	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 FROM PSR		-1,686	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-214,540	70.93
70.94	HRR adjustment amount (see instructions)		-170,565	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 7/6/2022 10:06 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		582,779	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		55,321,091	71.00	
71.01	Sequestration adjustment (see instructions)		0	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03	
72.00	Interim payments		53,635,866	72.00	
72.01	Interim payments-PARHM		0	72.01	
73.00	Tentative settlement (for contractor use only)		0	73.00	
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		1,685,225	74.00	
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		2,498,560	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
Comparison 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: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/6/2022 10:06 am

		Title XVIII		Hospital		PPS	
		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
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	32,810,383	0	32,810,383		32,810,383
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,810,382	0		10,810,382	10,810,382
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	933,421	0	933,421		933,421
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	312,094	0		312,094	312,094
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	54,857,110	0	40,465,287	14,391,823	54,857,110
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.035041	0.035041	0.035041	0.035041	
6.00	IME payment adjustment (see instructions)	22.00	827,137	0	622,151	204,986	827,137
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,040,201	0	767,303	272,898	1,040,201
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	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	827,137	0	622,151	204,986	827,137
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,040,201	0	767,303	272,898	1,040,201
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1654	0.1654	0.1654	0.1654	
11.00	Disproportionate share adjustment (see instructions)	34.00	1,803,718	0	1,356,709	447,009	1,803,718
11.01	Uncompensated care payments	36.00	6,418,306	0	5,040,971	1,377,335	6,418,306
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	53,915,441	0	40,763,635	13,151,806	53,915,441
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	54,955,642	0	41,530,938	13,424,704	54,955,642

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/6/2022 10:06 am

		Title XVIII		Hospital		PPS	
		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
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	3,648,157	0	2,745,542	902,615	3,648,157
17.00	Special add-on payments for new technologies	54.00	59,156	0	39,782	19,373	59,155
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	44,316,262	14,346,692	58,662,954
		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	3,325,742	0	2,503,983	821,759	3,325,742
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	43,053	0	31,225	11,828	43,053
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0146	0.0146	0.0146	0.0146	
23.00	Indirect medical education adjustment (see instructions)	6.00	48,556	0	36,558	11,998	48,556
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0694	0.0694	0.0694	0.0694	
25.00	Disproportionate share adjustment (see instructions)	11.00	230,806	0	173,776	57,030	230,806
26.00	Total prospective capital payments (see instructions)	12.00	3,648,157	0	2,745,542	902,615	3,648,157
		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	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/6/2022 10:06 am

		Title XVIII		Hospital		PPS	
		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	32,810,383	32,810,383		32,810,383	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,810,382		10,810,382	10,810,382	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	933,421	933,421		933,421	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	312,094		312,094	312,094	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	54,857,110	40,465,287	14,391,823	54,857,110	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.035041	0.035041	0.035041		5.00
6.00	IME payment adjustment (see instructions)	22.00	827,137	622,151	204,986	827,137	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,040,201	767,303	272,898	1,040,201	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	827,137	622,151	204,986	827,137	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,040,201	767,303	272,898	1,040,201	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1654	0.1654	0.1654		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,803,718	1,356,709	447,009	1,803,718	11.00
11.01	Uncompensated care payments	36.00	6,418,306	5,040,971	1,377,335	6,418,306	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	53,915,441	40,763,635	13,151,806	53,915,441	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	54,955,642	41,530,938	13,424,704	54,955,642	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	3,648,157	2,745,542	902,615	3,648,157	16.00
17.00	Special add-on payments for new technologies	54.00	59,156	39,783	19,373	59,156	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			44,316,263	14,346,692	58,662,955	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/6/2022 10:06 am

		Title XVIII		Hospital		PPS	
		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	3,325,742	2,503,983	821,759	3,325,742	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	43,053	31,225	11,828	43,053	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	0.0146	0.0146	0.0146		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	48,556	36,558	11,998	48,556	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0694	0.0694	0.0694		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	230,806	173,776	57,030	230,806	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3,648,157	2,745,542	902,615	3,648,157	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	-214,540	-214,540	0	-214,540	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	-170,565	-141,325	-29,240	-170,565	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		439,604	143,175	582,779	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 7/6/2022 10:06 am
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		25,637	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		40,520,269	2.00
3.00	OPPS payments		35,814,773	3.00
4.00	Outlier payment (see instructions)		29,872	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		11,887	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		25,637	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		127,213	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)		127,213	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)		127,213	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		101,576	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)		25,637	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		35,856,532	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)		6,555,486	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)		29,326,683	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		356,998	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)		29,683,681	30.00
31.00	Primary payer payments		19,586	31.00
32.00	Subtotal (line 30 minus line 31)		29,664,095	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)		623,489	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		405,268	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		312,068	36.00
37.00	Subtotal (see instructions)		30,069,363	37.00
38.00	MSP-LCC reconciliation amount from PS&R		1,944	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		30,067,419	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		30,135,371	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-67,952	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 7/6/2022 10:06 am
		Title XVIII	Hospital	PPS
				1.00
MEDICARE PART B ANCILLARY COSTS				
200.00	Part B Combined Billed Days			0 200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part I
Date/Time Prepared:
7/6/2022 10:06 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		53,635,866		30,135,371	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)		53,635,866		30,135,371	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		1,685,225		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		67,952	6.02
7.00	Total Medicare program liability (see instructions)		55,321,091		30,067,419	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 26-0104 Component CCN: 26-S104	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part I Date/Time Prepared: 7/6/2022 10:06 am	
		Title XVIII	Subprovider - IPF	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		1,150,386		0 1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0 2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/01/2021	41,500		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)		41,500		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)		1,191,886		0 4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0 5.01
5.02			0		0 5.02
5.03			0		0 5.03
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0 5.50
5.51			0		0 5.51
5.52			0		0 5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0 5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		0		0 6.01
6.02	SETTLEMENT TO PROGRAM		42,261		0 6.02
7.00	Total Medicare program liability (see instructions)		1,149,625		0 7.00
				Contractor Number	NPR Date (Mo/Day/Yr)
		0		1.00	2.00
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 26-0104

Period:

Worksheet E-1

Component CCN: 26-5842

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
7/6/2022 10:06 am

Title XVIII

Skilled Nursing
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider				0	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		2,092,599		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	12/01/2020	65,100		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		65,100		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,157,699		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		19,842		0	6.02
7.00	Total Medicare program liability (see instructions)		2,137,857		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 7/6/2022 10:06 am
		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 (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

Health Financial Systems		SSM HEALTH DEPAUL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0104	Period: From 01/01/2021	Worksheet E-3	
		Component CCN: 26-S104	To 12/31/2021	Part II Date/Time Prepared: 7/6/2022 10:06 am	
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
PART II - MEDICARE PART A SERVICES - IPF PPS					
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,314,599	1.00
2.00	Net IPF PPS Outlier Payments			24,721	2.00
3.00	Net IPF PPS ECT Payments			0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	4.01
5.00	New Teaching program adjustment. (see instructions)			0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00	8.00
9.00	Average Daily Census (see instructions)			11.561644	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,339,320	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0	15.00
16.00	Subtotal (see instructions)			1,339,320	16.00
17.00	Primary payer payments			0	17.00
18.00	Subtotal (line 16 less line 17).			1,339,320	18.00
19.00	Deductibles			126,140	19.00
20.00	Subtotal (line 18 minus line 19)			1,213,180	20.00
21.00	Coinsurance			120,918	21.00
22.00	Subtotal (line 20 minus line 21)			1,092,262	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			73,894	23.00
24.00	Adjusted reimbursable bad debts (see instructions)			48,031	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			22,372	25.00
26.00	Subtotal (sum of lines 22 and 24)			1,140,293	26.00
27.00	Direct graduate medical education payments (see instructions)			0	27.00
28.00	Other pass through costs (see instructions)			9,332	28.00
29.00	Outlier payments reconciliation			0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	30.50
30.98	Recovery of accelerated depreciation.			0	30.98
30.99	Demonstration payment adjustment amount before sequestration			0	30.99
31.00	Total amount payable to the provider (see instructions)			1,149,625	31.00
31.01	Sequestration adjustment (see instructions)			0	31.01
31.02	Demonstration payment adjustment amount after sequestration			0	31.02
32.00	Interim payments			1,191,886	32.00
33.00	Tentative settlement (for contractor use only)			0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			-42,261	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	35.00
TO BE COMPLETED BY CONTRACTOR					
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			24,721	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0	51.00
52.00	The rate used to calculate the Time Value of Money			0.00	52.00
53.00	Time Value of Money (see instructions)			0	53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE					
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0104 Component CCN: 26-5842	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VI Date/Time Prepared: 7/6/2022 10:06 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		2,382,794	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,382,794	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		297,542	7.00
8.00	Allowable bad debts (see instructions)		80,931	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		24,144	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		52,605	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		2,137,857	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.98	Recovery of accelerated depreciation.		0	14.98
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		2,137,857	15.00
15.01	Sequestration adjustment (see instructions)		0	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)		0	15.75
16.00	Interim payments		2,157,699	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)		-19,842	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 7/6/2022 10:06 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care 1.00	Other 2.00	Total 3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		14.25		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		14.25		10.01
11.00	Total weighted FTE count	0.00	14.25		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	14.53		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	14.01		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	14.26		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	14.26		17.00
18.00	Per resident amount	129,493.66	129,493.66		18.00
19.00	Approved amount for resident costs	0	1,846,580	1,846,580	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,846,580	25.00
		Inpatient Part A 1.00	Managed Care 2.00	Total 3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	23,473	29,326		26.00
27.00	Total Inpatient Days (see instructions)	104,780	104,780		27.00
28.00	Ratio of inpatient days to total inpatient days	0.224022	0.279882		28.00
29.00	Program direct GME amount	413,675	516,825	930,500	29.00
29.01	Percent reduction for MA DGME		4.07		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		21,035	21,035	30.00
31.00	Net Program direct GME amount			909,465	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 7/6/2022 10:06 am	
		Title XVIII	Hospital	PPS	
			1.00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0		32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		6,861,425		33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000		34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0		35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0		36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)		62,792,397		37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0		38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0		39.00
40.00	Primary payer payments (see instructions)		57,895		40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		62,734,502		41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)		40,557,793		42.00
43.00	Primary payer payments (see instructions)		19,586		43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		40,538,207		44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		103,272,709		45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.607464		46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.392536		47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)		909,465		48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		552,467		49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		356,998		50.00

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

Provider CCN: 26-0104

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

Worksheet G

Date/Time Prepared:
7/6/2022 10:06 am

		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	7,265	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	176,607,290	0	0	0	4.00
5.00	Other receivable	3,920,668	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-105,513,689	0	0	0	6.00
7.00	Inventory	9,971,724	0	0	0	7.00
8.00	Prepaid expenses	1,276,739	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	86,269,997	0	0	0	11.00
FIXED ASSETS						
12.00	Land	10,400,000	0	0	0	12.00
13.00	Land improvements	3,145,855	0	0	0	13.00
14.00	Accumulated depreciation	-2,592,787	0	0	0	14.00
15.00	Buildings	128,499,212	0	0	0	15.00
16.00	Accumulated depreciation	-66,764,279	0	0	0	16.00
17.00	Leasehold improvements	3,413,535	0	0	0	17.00
18.00	Accumulated depreciation	-2,949,219	0	0	0	18.00
19.00	Fixed equipment	4,745,229	0	0	0	19.00
20.00	Accumulated depreciation	-2,811,428	0	0	0	20.00
21.00	Automobiles and trucks	62,885	0	0	0	21.00
22.00	Accumulated depreciation	-57,416	0	0	0	22.00
23.00	Major movable equipment	114,920,031	0	0	0	23.00
24.00	Accumulated depreciation	-74,329,682	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)	115,681,936	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	9,323,082	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	15,149,997	6,863,904	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	24,473,079	6,863,904	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	226,425,012	6,863,904	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	-45,081,023	0	0	0	37.00
38.00	Salaries, wages, and fees payable	13,151,863	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	450,184	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	40,370,211	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,891,235	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	-43,270,382	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-43,270,382	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-34,379,147	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	260,804,159				52.00
53.00	Specific purpose fund		6,863,904			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)	260,804,159	6,863,904	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	226,425,012	6,863,904	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 26-0104

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

Worksheet G-1

Date/Time Prepared:
7/6/2022 10:06 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		251,920,056		2,276,758		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		42,232,282				2.00
3.00	Total (sum of line 1 and line 2)		294,152,338		2,276,758		3.00
4.00	Additions (credit adjustments)	-33,348,179		4,587,146		-138,956	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		-33,348,179		4,587,146		10.00
11.00	Subtotal (line 3 plus line 10)		260,804,159		6,863,904		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		260,804,159		6,863,904		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	138,956		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)	138,956		0			3.00
4.00	Additions (credit adjustments)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	-138,956		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 26-0104

Period:
From 01/01/2021
To 12/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
7/6/2022 10:06 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	92,825,003		92,825,003	1.00
2.00	SUBPROVIDER - IPF	8,453,957		8,453,957	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	6,983,950		6,983,950	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)	108,262,910		108,262,910	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	146,987,217		146,987,217	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	146,987,217		146,987,217	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	255,250,127		255,250,127	17.00
18.00	Ancillary services	455,513,900	735,909,384	1,191,423,284	18.00
19.00	Outpatient services	62,866,839	111,394,208	174,261,047	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	NON REIMBURSABLE PROFESSIONAL FEES	2,655,177	6,224,162	8,879,339	27.00
27.01	EMPLOYEE HEALTH INSURANCE	10,024,465	20,641,102	30,665,567	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	786,310,508	874,168,856	1,660,479,364	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		485,967,829		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)		485,967,829		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 26-0104

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

Worksheet G-3

Date/Time Prepared:
7/6/2022 10:06 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,660,479,364	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,195,735,370	2.00
3.00	Net patient revenues (line 1 minus line 2)	464,743,994	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	485,967,829	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-21,223,835	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	1,165,522	6.00
7.00	Income from investments	689,324	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	1,501	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,403,146	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	56,482	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	1,116,072	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	62,803,833	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	67,235,880	25.00
26.00	Total (line 5 plus line 25)	46,012,045	26.00
27.00	OTHER EXPENSES	3,779,763	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	3,779,763	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	42,232,282	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 26-0104	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 7/6/2022 10:06 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,325,742	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		43,053	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)		278.05	3.00
4.00	Number of interns & residents (see instructions)		14.26	4.00
5.00	Indirect medical education percentage (see instructions)		1.46	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)		48,556	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		5.81	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		27.31	8.00
9.00	Sum of lines 7 and 8		33.12	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.94	10.00
11.00	Disproportionate share adjustment (see instructions)		230,806	11.00
12.00	Total prospective capital payments (see instructions)		3,648,157	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