

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	PROVIDER CCN: 11-0028	PERIOD: FROM: 01/01/2021 TO: 12/31/2021	WORKSHEET D PART I
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Check	<input type="checkbox"/> Title V	<input checked="" type="checkbox"/> Hospital	<input checked="" type="checkbox"/> PPS
Applicable	<input checked="" type="checkbox"/> Title XVIII	<input type="checkbox"/> PARHM Demonstration	<input type="checkbox"/> TEFRA
Boxes:	<input type="checkbox"/> Title XIX	<input type="checkbox"/> Chart Model	

	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)		
COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7		
INPATIENT ROUTINE SERVICE COST CENTERS									
30	Adults and Pediatrics (General Routine Care)	5,316,539		5,316,539	83,011	64	8,056	515,987	30
31	Intensive Care Unit	5,008,909		5,008,909	45,795	109	23,716	2,594,056	31
31.01	02060NEURO INTENSIVE CARE UNIT	341,687		341,687	3,660	93	1,098	102,509	31.01
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider (specify)								42
43	Nursery	122,909		122,909	5,196	24			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
46	Other Long Term Care								46
200	Total	10,790,044		10,790,044	137,662		32,870	3,212,552	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		PROVIDER CCN: 11-0028	PERIOD: FROM: 01/01/2021 TO: 12/31/2021	WORKSHEET D PART II			
Check	<input type="checkbox"/> Title V	<input checked="" type="checkbox"/> Hospital	<input checked="" type="checkbox"/> PPS				
Applicable	<input checked="" type="checkbox"/> Title XVIII	<input type="checkbox"/> PARHM Demonstration	<input type="checkbox"/> TEFRA				
Boxes:	<input type="checkbox"/> Title XIX	<input type="checkbox"/> Chart Model					
COST CENTER DESCRIPTIONS		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Pt I, col 8)	Ratio of Cost to Charges (col. 1 / col. 2)	Inpatient Program Charges	Capital Costs (col.3 x col. 4)	
		1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,589,158	154,962,808	0	18,268,781	894,695	50
52	Labor Room and Delivery Room	694,994	6,464,878	0	5,784	622	52
53	Anesthesiology	221,376	12,297,311	0	1,522,298	27,404	53
54	Radiology-Diagnostic	3,403,643	110,985,322	0	10,798,650	331,173	54
57	Computed Tomography (CT) Scan	307,899	112,970,068	0	13,658,501	37,219	57
58	Magnetic Resonance Imaging (MRI)	614,449	34,974,919	0	2,265,871	39,807	58
59	Cardiac Catheterization	1,319,074	58,505,703	0	7,270,041	163,910	59
60	Laboratory	1,564,708	189,938,354	0	24,741,499	203,820	60
64	Intravenous Therapy	142,350	13,279,278	0	991,486	10,629	64
65	Respiratory Therapy	467,602	43,395,998	0	5,396,902	58,152	65
66	Physical Therapy	323,067	18,231,731	0	4,045,054	71,678	66
69	Electrocardiology	809,695	69,118,465	0	7,152,252	83,789	69
71	Medical Supplies Charged to Patients	945,220	224,212,869	0	38,168,370	160,918	71
72	Implantable Devices Charged to Patients	1,196,446	97,801,249	0	17,426,690	213,181	72
73	Drugs Charged to Patients	1,203,018	221,303,529	0	41,913,653	227,843	73
76.97	07697CARDIAC REHABILITATION	261,578	3,584,943	0	9,030	659	76.97
OUTPATIENT SERVICE COST CENTERS							
90	Clinic	522,284	9,634,778	0	2,234,548	121,130	90
91	Emergency	2,998,194	55,878,654	0	5,889,018	315,975	91
92	Observation Beds	562,456	14,540,314	0	766,762	29,661	92
OTHER REIMBURSABLE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
200	Total (sum of lines 50 through 199)	25,147,211	1,452,081,171		202,525,190	2,992,265	200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS-THROUGH COSTS	PROVIDER CCN: 11-0028	PERIOD: FROM: 01/01/2021 TO: 12/31/2021	WORKSHEET D PART III
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Check	<input type="checkbox"/> Title V	<input checked="" type="checkbox"/> Hospital	<input checked="" type="checkbox"/> PPS
Applicable	<input checked="" type="checkbox"/> Title XVIII	<input type="checkbox"/> PARHM Demonstration	<input type="checkbox"/> TEFRA
Boxes:	<input type="checkbox"/> Title XIX	<input type="checkbox"/> Chart Model	

	COST CENTER DESCRIPTIONS	Nursing Program		Allied Health		All Other Medical	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1, 2, and 3, minus col. 4)	Total Patient Days	Per Diem (col. 3 / col. 4)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
		Post-Stepdown Adjustments	Nursing Program	Post-Stepdown Adjustments	Allied Health Cost	Education Cost							
		1A	1	2A	2	3	4	5	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS												
30	Adults and Pediatrics (General Routine Care)								83,011		8,056		30
31	Intensive Care Unit								45,795		23,716		31
31.01	02060NEURO INTENSIVE CARE UNIT								3,660		1,098		31.01
32	Coronary Care Unit												32
33	Burn Intensive Care Unit												33
34	Surgical Intensive Care Unit												34
35	Other Special Care (specify)												35
40	Subprovider - IPF												40
41	Subprovider - IRF												41
42	Subprovider (specify)												42
43	Nursery								5,196				43
44	Skilled Nursing Facility												44
45	Nursing Facility												45
46	Other Long Term Care												46
200	Total								137,662		32,870		200

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS-THROUGH COSTS				PROVIDER CCN: 11-0028		PERIOD: FROM: 01/01/2021 TO: 12/31/2021		WORKSHEET D PART IV	
Check Applicable Boxes:	<input type="checkbox"/> Title V <input checked="" type="checkbox"/> Title XVIII, PART A <input type="checkbox"/> Title XIX	<input checked="" type="checkbox"/> Hospital <input type="checkbox"/> IPF <input type="checkbox"/> IRF <input type="checkbox"/> Subprovider (Other)	<input type="checkbox"/> SNF <input type="checkbox"/> NF <input type="checkbox"/> ICF/IID <input type="checkbox"/> Swing-Bed SNF	<input checked="" type="checkbox"/> Hospital <input type="checkbox"/> PARHM Demonstration <input type="checkbox"/> Chart Model <input type="checkbox"/> Chart CAH Swing-Bed SNF		<input checked="" type="checkbox"/> PPS <input type="checkbox"/> TEFRA <input type="checkbox"/> Other			

COST CENTER DESCRIPTIONS		1	2A	2	3A	3	4	5	6	
		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	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)	
ANCILLARY SERVICE COST CENTERS										
50	Operating Room									50
51	Recovery Room									51
52	Labor Room and Delivery Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic					321,955		321,955	321,955	54
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	Computed Tomography (CT) Scan									57
58	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catheterization									59
60	Laboratory									60
61	PBP Clinical Laboratory Services-Program Only									61
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									63
64	Intravenous Therapy									64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology					168,392		168,392	168,392	69
70	Electroencephalography									70
71	Medical Supplies Charged to Patients									71
72	Implantable Devices Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
75	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76
76.97	07697CARDIAC REHABILITATION									76.97
OUTPATIENT SERVICE COST CENTERS										
88	Rural Health Clinic (RHC)									88
89	Federally Qualified Health Center (FQHC)									89
90	Clinic									90
91	Emergency									91
92	Observation Beds									92
93	Other Outpatient Service (specify)									93
200	Total (sum of lines 50 through 199)					490,347		490,347	490,347	200

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS-THROUGH COSTS				PROVIDER CCN: 11-0028	PERIOD: FROM: 01/01/2021 TO: 12/31/2021	WORKSHEET D PART IV
Check Applicable Boxes:	<input type="checkbox"/> Title V <input checked="" type="checkbox"/> Title XVIII, PART A <input type="checkbox"/> Title XIX	<input checked="" type="checkbox"/> Hospital <input type="checkbox"/> IPF <input type="checkbox"/> IRF <input type="checkbox"/> Subprovider (Other)	<input type="checkbox"/> SNF <input type="checkbox"/> NF <input type="checkbox"/> ICF/IID <input type="checkbox"/> Swing-Bed SNF	<input checked="" type="checkbox"/> Hospital <input type="checkbox"/> PARHM Demonstration <input type="checkbox"/> Chart Model <input type="checkbox"/> Chart CAH Swing-Bed SNF	<input checked="" type="checkbox"/> PPS <input type="checkbox"/> TEFRA <input type="checkbox"/> Other	

		Total Charges (from Wkst. C, Pt I, col 8)	Ratio of Cost to Charges (col. 5 / col. 7) (see instructions)	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)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	154,962,808			18,268,781		25,787,968		50
51	Recovery Room								51
52	Labor Room and Delivery Room	6,464,878			5,784		973		52
53	Anesthesiology	12,297,311			1,522,298		1,613,808		53
54	Radiology-Diagnostic	110,985,322	0	0	10,798,650	31,327	19,628,458	56,942	54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan	112,970,068			13,658,501		16,402,455		57
58	Magnetic Resonance Imaging (MRI)	34,974,919			2,265,871		6,800,351		58
59	Cardiac Catheterization	58,505,703			7,270,041		12,339,377		59
60	Laboratory	189,938,354			24,741,499		7,965,932		60
61	PBP Clinical Laboratory Services-Program Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Trans.								63
64	Intravenous Therapy	13,279,278			991,486		779,023		64
65	Respiratory Therapy	43,395,998			5,396,902		1,886,098		65
66	Physical Therapy	18,231,731			4,045,054		172,225		66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology	69,118,465	0	0	7,152,252	17,423	14,516,289	35,362	69
70	Electroencephalography								70
71	Medical Supplies Charged to Patients	224,212,869			38,168,370		23,422,068		71
72	Implantable Devices Charged to Patients	97,801,249			17,426,690		19,502,173		72
73	Drugs Charged to Patients	221,303,529			41,913,653		12,291,821		73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
76.97	07697CARDIAC REHABILITATION	3,584,943			9,030		974,100		76.97
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic	9,634,778			2,234,548		2,716,876		90
91	Emergency	55,878,654			5,889,018		3,494,419		91
92	Observation Beds	14,540,314			766,762		721,116		92
93	Other Outpatient Service (specify)								93
200	Total (sum of lines 50 through 199)	1,452,081,171			202,525,190	48,750	171,015,530	92,304	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS	PROVIDER CCN: 11-0028	PERIOD: FROM: 01/01/2021 TO: 12/31/2021	WORKSHEET D PART V
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Check Applicable Boxes:	<input type="checkbox"/> Title V - O/P <input checked="" type="checkbox"/> Title XVIII, PART B <input type="checkbox"/> Title XIX - O/P	<input checked="" type="checkbox"/> Hospital <input type="checkbox"/> IPF <input type="checkbox"/> IRF	<input type="checkbox"/> Subprovider (Other) <input type="checkbox"/> SNF <input type="checkbox"/> NF	<input type="checkbox"/> Swing-Bed SNF <input type="checkbox"/> Swing-Bed NF <input type="checkbox"/> ICF/IID	<input type="checkbox"/> PARHM Demonstration <input type="checkbox"/> PARHM CAH Swing-Bed SNF <input type="checkbox"/> Chart Model <input type="checkbox"/> Chart CAH Swing-Bed SNF
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COST CENTER DESCRIPTIONS	Cost to Charge Ratio from Wkst. C, Pt. I, col. 9	Program Charges			Program Cost				
		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.)	Cost Reimbursed Services Subject to Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see inst.)		
	1	2	3	4	5	6	7		
ANCILLARY SERVICE COST CENTERS									
50	Operating Room	0.313616	25,787,968		8,087,519			50	
52	Labor Room and Delivery Room	1.292925	973		1,258			52	
53	Anesthesiology	0.064781	1,613,808		104,544			53	
54	Radiology-Diagnostic	0.173856	19,628,458		3,412,525			54	
57	Computed Tomography (CT) Scan	0.026802	16,402,455		439,619			57	
58	Magnetic Resonance Imaging (MRI)	0.054231	6,800,351		368,790			58	
59	Cardiac Catheterization	0.144768	12,339,377		1,786,347			59	
60	Laboratory	0.139796	7,965,932		1,113,605			60	
64	Intravenous Therapy	0.067724	779,023		52,759			64	
65	Respiratory Therapy	0.190323	1,886,098		358,968			65	
66	Physical Therapy	0.380333	172,225		65,503			66	
69	Electrocardiology	0.079732	14,516,289		1,157,413			69	
71	Medical Supplies Charged to Patients	0.181395	23,422,068	171,200	4,248,646	31,055		71	
72	Implantable Devices Charged to Patients	0.534358	19,502,173	4,355	10,421,142	2,327		72	
73	Drugs Charged to Patients	0.168173	12,291,821	166	87,721	2,067,152	28	14,752	
76.97	07697CARDIAC REHABILITATION	0.545560	974,100		531,430			76.97	
OUTPATIENT SERVICE COST CENTERS									
90	Clinic	0.853728	2,716,876	46	2,319,473	39		90	
91	Emergency	0.603146	3,494,419		2,107,645			91	
92	Observation Beds	0.554390	721,116		399,779			92	
OTHER REIMBURSABLE COST CENTERS									
SPECIAL PURPOSE COST CENTERS									
200	Subtotal (see instructions)		171,015,530	175,767	87,721	39,044,117	33,449	14,752	200
201	Less PBP Clinic Lab. Services - Program Only Charges								201
202	Net Charges (line 200 - line 201)		171,015,530	175,767	87,721	39,044,117	33,449	14,752	202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

PROVIDER CCN:
11-0028

PERIOD:
FROM: 01/01/2021
TO: 12/31/2021

WORKSHEET D
PART V

Check	<input type="checkbox"/> Title V - O/P	<input checked="" type="checkbox"/> Hospital	<input type="checkbox"/> Subprovider (Other)	<input type="checkbox"/> Swing-Bed SNF	<input type="checkbox"/> PARHM Demonstration
Applicable	<input type="checkbox"/> Title XVIII, PART B	<input type="checkbox"/> IPF	<input type="checkbox"/> SNF	<input type="checkbox"/> Swing-Bed NF	<input type="checkbox"/> PARHM CAH Swing-Bed SNF
Boxes:	<input checked="" type="checkbox"/> Title XIX - O/P	<input type="checkbox"/> IRF	<input type="checkbox"/> NF	<input type="checkbox"/> ICF/IID	<input type="checkbox"/> Chart Model <input type="checkbox"/> Chart CAH Swing-Bed SNF

COST CENTER DESCRIPTIONS	Cost to Charge Ratio from Wkst. C, Pt. I, col. 9	Program Charges			Program Cost			
		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)	Cost Reimbursed Services Subject to Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see inst.)	
	1	2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.313616		1,001,296		314,022		50
52	Labor Room and Delivery Room	1.292925		25,726		33,262		52
54	Radiology-Diagnostic	0.173856		3,856,413		670,461		54
60	Laboratory	0.139796		442,387		61,844		60
65	Respiratory Therapy	0.190323		31,638		6,021		65
66	Physical Therapy	0.380333		19,690		7,489		66
69	Electrocardiology	0.079732		758,097		60,445		69
71	Medical Supplies Charged to Patients	0.181395		1,037,404		188,180		71
72	Implantable Devices Charged to Patients	0.534358		11,169		5,968		72
73	Drugs Charged to Patients	0.168173		1,001,170		168,370		73
OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.603146		1,499,294		904,293		91
92	Observation Beds	0.554390		112,531		62,386		92
OTHER REIMBURSABLE COST CENTERS								
SPECIAL PURPOSE COST CENTERS								
200	Subtotal (see instructions)			9,796,815		2,482,741		200
201	Less PBP Clinic Lab. Services - Program Only Charges							201
202	Net Charges (line 200 - line 201)			9,796,815		2,482,741		202

COMPUTATION OF INPATIENT OPERATING COST		PROVIDER CCN: 11-0028	PERIOD: FROM: 01/01/2021 TO: 12/31/2021	WORKSHEET D-1, PART I
Check Applicable Boxes:	<input type="checkbox"/> Title V - O/P <input checked="" type="checkbox"/> Title XVIII, PART A <input type="checkbox"/> Title XIX - I/P	<input checked="" type="checkbox"/> Hospital <input type="checkbox"/> IPF <input type="checkbox"/> IRF <input type="checkbox"/> Subprovider (Other) <input type="checkbox"/> SNF	<input type="checkbox"/> NF <input type="checkbox"/> ICF/IID <input type="checkbox"/> NF <input type="checkbox"/> PARHM Demonstration <input type="checkbox"/> Chart Model	<input checked="" type="checkbox"/> PPS <input type="checkbox"/> TEFRA <input type="checkbox"/> Other

PART I - ALL PROVIDER COMPONENTS			1
INPATIENT DAYS			
1	Inpatient days (including private room days and swing-bed days, excluding newborn)		83,011
2	Inpatient days (including private room days, excluding swing-bed and newborn days)		83,011
3	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		
4	Semi-private room days (excluding swing-bed and observation bed days)		74,229
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if 6 calendar year, enter 0 on this line)		
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if 8 calendar year, enter 0 on this line)		
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		8,056
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the 10 cost reporting period (see instructions).		
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the 11 cost reporting period (if calendar year, enter 0 on this line)		
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of 12 the cost reporting period.		
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the 13 cost reporting period (if calendar year, enter 0 on this line)		
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)		
15	Total nursery days (title V or XIX only)		
16	Nursery days (title V or XIX only)		
SWING BED ADJUSTMENT			
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		
21	Total general inpatient routine service cost (see instructions)		76,195,636
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		
26	Total swing-bed cost (see instructions)		
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		76,195,636
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		
29	Private room charges (excluding swing-bed charges)		
30	Semi-private room charges (excluding swing-bed charges)		
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		
32	Average private room per diem charge (line 29 ÷ line 3)		
33	Average semi-private room per diem charge (line 30 ÷ line 4)		
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		
35	Average per diem private room cost differential (line 34 x line 31)		
36	Private room cost differential adjustment (line 3 x line 35)		
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		76,195,636

COMPUTATION OF INPATIENT OPERATING COST		PROVIDER CCN: 11-0028	PERIOD: FROM: 01/01/2021 TO: 12/31/2021	WORKSHEET D-1, PART II
Check Applicable Boxes:	<input type="checkbox"/> Title V - O/P <input checked="" type="checkbox"/> Title XVIII, PART A <input type="checkbox"/> Title XIX - I/P	<input checked="" type="checkbox"/> Hospital <input type="checkbox"/> IPF <input type="checkbox"/> IRF <input type="checkbox"/> Subprovider (Other) <input type="checkbox"/> SNF	<input type="checkbox"/> NF <input type="checkbox"/> ICF/IID <input type="checkbox"/> NF <input type="checkbox"/> PARHM Demonstration <input type="checkbox"/> Chart Model	<input checked="" type="checkbox"/> PPS <input type="checkbox"/> TEFRA <input type="checkbox"/> Other

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	Adjusted general inpatient routine service cost per diem (see instructions)		918	38
39	Program general inpatient routine service cost (line 9 x line 38)		7,394,602	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40
41	Total Program general inpatient routine service cost (line 39 + line 40)		7,394,602	41

	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 / col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1	2	3	4	5		
42	Nursery (title V & XIX only)					42	
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	56,124,097	45,795	1,226	23,716	29,065,144	43
43.01	02060NEURO INTENSIVE CARE UNIT	5,892,730	3,660	1,610	1,098	1,767,824	43.01
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care Unit (specify)						47

48	Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200)		45,090,138	48
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)			48.01
49	Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions)		83,317,708	49

PASS-THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)		3,212,552	50
51	Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV)		3,041,015	51
52	Total Program excludable cost (sum of lines 50 and 51)		6,253,567	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)		77,064,141	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges			54
55	Target amount per discharge			55
55.01	Permanent adjustment amount per discharge			55.01
55.02	Adjustment amount per discharge (contractor use only)			55.02
56	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)			56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)			57
58	Bonus payment (see instructions)			58
59	Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)			59
60	Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)			60
61	Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the 61 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
62	Relief payment (see instructions)			62
63	Allowable Inpatient cost plus incentive payment (see instructions)			63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (title XVIII only)			64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (title XVIII only)			65
66	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only; for CAH, see instructions)			66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)			67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)			68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)			69

COMPUTATION OF INPATIENT OPERATING COST		PROVIDER CCN: 11-0028	PERIOD: FROM: 01/01/2021 TO: 12/31/2021	WORKSHEET D-1, PARTS III & IV
Check Applicable Boxes:	<input type="checkbox"/> Title V - O/P <input checked="" type="checkbox"/> Title XVIII, PART A <input type="checkbox"/> Title XIX - I/P	<input checked="" type="checkbox"/> Hospital <input type="checkbox"/> IPF <input type="checkbox"/> IRF <input type="checkbox"/> Subprovider (Other) <input type="checkbox"/> SNF	<input type="checkbox"/> NF <input type="checkbox"/> ICF/IID <input type="checkbox"/> NF <input type="checkbox"/> PARHM Demonstration <input type="checkbox"/> Chart Model	<input checked="" type="checkbox"/> PPS <input type="checkbox"/> TEFRA <input type="checkbox"/> Other

PART III - SNF, NF, AND ICF/IID ONLY

70	SNF / NF / ICF/IID routine service cost (line 37)		70
71	Adjusted general inpatient routine service cost per diem (line 70 + line 2)		71
72	Program routine service cost (line 9 x line 71)		72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)		74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75
76	Per diem capital-related costs (line 75 + line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)		83
84	Program inpatient ancillary services (see instructions)		84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)		86

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)	8,782	87
88	Adjusted general inpatient routine cost per diem (line 27 + line 2)	918	88
89	Observation bed cost (line 87 x line 88) (see instructions)	8,060,998	89

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	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	2	3	4	5	
90					5,316,539	90
91	Capital-related cost					
92	Nursing Program cost					91
93	Allied Health cost					92
94	All other Medical Education					93

COMPUTATION OF INPATIENT OPERATING COST		PROVIDER CCN: 11-0028	PERIOD: FROM: 01/01/2021 TO: 12/31/2021	WORKSHEET D-1, PART I
Check Applicable Boxes:	<input type="checkbox"/> Title V - O/P <input type="checkbox"/> Title XVIII, PART A <input checked="" type="checkbox"/> Title XIX - I/P	<input checked="" type="checkbox"/> Hospital <input type="checkbox"/> IPF <input type="checkbox"/> IRF <input type="checkbox"/> Subprovider (Other) <input type="checkbox"/> SNF	<input type="checkbox"/> NF <input type="checkbox"/> ICF/IID <input type="checkbox"/> NF <input type="checkbox"/> PARHM Demonstration <input type="checkbox"/> Chart Model	<input checked="" type="checkbox"/> PPS <input type="checkbox"/> TEFRA <input type="checkbox"/> Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS		1	
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	83,011	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	83,011	2
3	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed and observation bed days)	74,229	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if 6 calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if 8 calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,143	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the 10 cost reporting period (see instructions).		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the 11 cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of 12 the cost reporting period.		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the 13 cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	5,196	15
16	Nursery days (title V or XIX only)	130	16
SWING BED ADJUSTMENT			
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	76,195,636	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	76,195,636	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	76,195,636	37

COMPUTATION OF INPATIENT OPERATING COST			PROVIDER CCN: 11-0028	PERIOD: FROM: 01/01/2021 TO: 12/31/2021	WORKSHEET D-1, PART II
Check Applicable Boxes:	<input type="checkbox"/> Title V - O/P <input type="checkbox"/> Title XVIII, PART A <input checked="" type="checkbox"/> Title XIX - I/P	<input checked="" type="checkbox"/> Hospital <input type="checkbox"/> IPF <input type="checkbox"/> IRF <input type="checkbox"/> Subprovider (Other) <input type="checkbox"/> SNF	<input type="checkbox"/> NF <input type="checkbox"/> ICF/IID <input type="checkbox"/> NF <input type="checkbox"/> PARHM Demonstration <input type="checkbox"/> Chart Model	<input checked="" type="checkbox"/> PPS <input type="checkbox"/> TEFRA <input type="checkbox"/> Other	

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	Adjusted general inpatient routine service cost per diem (see instructions)				918	38
39	Program general inpatient routine service cost (line 9 x line 38)				1,967,060	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)					40
41	Total Program general inpatient routine service cost (line 39 + line 40)				1,967,060	41

	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 / col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1	2	3	4	5		
42	Nursery (title V & XIX only)	1,413,053				42	
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	56,124,097	45,795	1,226	4,832	5,921,858	43
43.01	02060NEURO INTENSIVE CARE UNIT	5,892,730	3,660	1,610	210	338,108	43.01
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care Unit (specify)						47
					1		
48	Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200)				6,634,201	48	
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					48.01	
49	Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions)				14,896,581	49	

PASS-THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)					50
51	Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV)					51
52	Total Program excludable cost (sum of lines 50 and 51)					52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)					53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges					54
55	Target amount per discharge					55
55.01	Permanent adjustment amount per discharge					55.01
55.02	Adjustment amount per discharge (contractor use only)					55.02
56	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					57
58	Bonus payment (see instructions)					58
59	Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					59
60	Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)					60
61	Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the 61 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.					61
62	Relief payment (see instructions)					62
63	Allowable Inpatient cost plus incentive payment (see instructions)					63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (title XVIII only)					64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (title XVIII only)					65
66	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only; for CAH, see instructions)					66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					69

COMPUTATION OF INPATIENT OPERATING COST			PROVIDER CCN: 11-0028	PERIOD: FROM: 01/01/2021 TO: 12/31/2021	WORKSHEET D-1, PARTS III & IV
Check Applicable Boxes:	<input type="checkbox"/> Title V - O/P <input type="checkbox"/> Title XVIII, PART A <input checked="" type="checkbox"/> Title XIX - I/P	<input checked="" type="checkbox"/> Hospital <input type="checkbox"/> IPF <input type="checkbox"/> IRF <input type="checkbox"/> Subprovider (Other) <input type="checkbox"/> SNF	<input type="checkbox"/> NF <input type="checkbox"/> ICF/IID <input type="checkbox"/> NF <input type="checkbox"/> PARHM Demonstration <input type="checkbox"/> Chart Model	<input checked="" type="checkbox"/> PPS <input type="checkbox"/> TEFRA <input type="checkbox"/> Other	

PART III - SNF, NF, AND ICF/IID ONLY

70	SNF / NF / ICF/IID routine service cost (line 37)		70
71	Adjusted general inpatient routine service cost per diem (line 70 + line 2)		71
72	Program routine service cost (line 9 x line 71)		72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)		74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75
76	Per diem capital-related costs (line 75 + line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)		83
84	Program inpatient ancillary services (see instructions)		84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)		86

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)	8,782	87
88	Adjusted general inpatient routine cost per diem (line 27 + line 2)	918	88
89	Observation bed cost (line 87 x line 88) (see instructions)	8,060,998	89

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	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	2	3	4	5	
90	Capital-related cost				5,316,539	90
91	Nursing Program cost					91
92	Allied Health cost					92
93	All other Medical Education					93

COMPUTATION OF INPATIENT OPERATING COST		PROVIDER CCN: 11-0028	PERIOD: FROM: 01/01/2021 TO: 12/31/2021	WORKSHEET D-3	
Check Applicable Boxes:	<input type="checkbox"/> Title V - O/P <input checked="" type="checkbox"/> Title XVIII, PART A <input type="checkbox"/> Title XIX - IP	<input checked="" type="checkbox"/> Hospital <input type="checkbox"/> IPF <input type="checkbox"/> IRF <input type="checkbox"/> Subprovider (Other)	<input type="checkbox"/> SNF <input type="checkbox"/> NF <input type="checkbox"/> Swing-Bed SNF <input type="checkbox"/> Swing-Bed NF	<input type="checkbox"/> ICF/IID <input type="checkbox"/> PARHM Demonstration <input type="checkbox"/> PARHM CAH Swing-Bed SNF <input type="checkbox"/> Chart Model <input type="checkbox"/> Chart CAH Swing-Bed SNF	<input checked="" type="checkbox"/> PPS <input type="checkbox"/> TEFRA <input type="checkbox"/> Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults and Pediatrics (General Routine Care)		6,575,980		30
31	Intensive Care Unit		23,100,734		31
31.01	02060NEURO INTENSIVE CARE UNIT		2,847,366		31.01
32	Coronary Care Unit				32
33	Burn Intensive Care Unit				33
34	Surgical Intensive Care Unit				34
35	Other Special Care (specify)				35
40	Subprovider - IPF				40
41	Subprovider - IRF				41
42	Subprovider (specify)				42
43	Nursery				43
ANCILLARY SERVICE COST CENTERS					
50	Operating Room	0.313616	18,268,781	5,729,382	50
51	Recovery Room				51
52	Labor Room and Delivery Room	1.292925	5,784	7,478	52
53	Anesthesiology	0.064781	1,522,298	98,616	53
54	Radiology-Diagnostic	0.173856	10,798,650	1,877,410	54
55	Radiology-Therapeutic				55
56	Radioisotope				56
57	Computed Tomography (CT) Scan	0.026802	13,658,501	366,075	57
58	Magnetic Resonance Imaging (MRI)	0.054231	2,265,871	122,880	58
59	Cardiac Catheterization	0.144768	7,270,041	1,052,469	59
60	Laboratory	0.139796	24,741,499	3,458,763	60
61	PBP Clinical Laboratory Services-Program Only				61
62	Whole Blood & Packed Red Blood Cells				62
63	Blood Storing, Processing, & Trans.				63
64	Intravenous Therapy	0.067724	991,486	67,147	64
65	Respiratory Therapy	0.190323	5,396,902	1,027,155	65
66	Physical Therapy	0.380333	4,045,054	1,538,468	66
67	Occupational Therapy				67
68	Speech Pathology				68
69	Electrocardiology	0.079732	7,152,252	570,263	69
70	Electroencephalography				70
71	Medical Supplies Charged to Patients	0.181395	38,168,370	6,923,551	71
72	Implantable Devices Charged to Patients	0.534358	17,426,690	9,312,091	72
73	Drugs Charged to Patients	0.168173	41,913,653	7,048,745	73
74	Renal Dialysis				74
75	ASC (Non-Distinct Part)				75
76	Other Ancillary (specify)				76
76.97	07697CARDIAC REHABILITATION	0.545560	9,030	4,926	76.97
OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic (RHC)				88
89	Federally Qualified Health Center (FQHC)				89
90	Clinic	0.853728	2,234,548	1,907,696	90
91	Emergency	0.603146	5,889,018	3,551,938	91
92	Observation Beds	0.554390	766,762	425,085	92
93	Other Outpatient Service (specify)				93
OTHER REIMBURSABLE COST CENTERS					
94	Home Program Dialysis				94
95	Ambulance Services				95
96	Durable Medical Equipment-Rented				96
97	Durable Medical Equipment-Sold				97
98	Other Reimbursable (specify)				98
99	Outpatient Rehabilitation Provider (specify)				99
100	Intern-Resident Service (not appvd. tchnng. prgm.)				100
101	Home Health Agency				101
101.01					101
101.02					101
200	Total (sum of lines 50 through 94 and 96 through 98)		202,525,190	45,090,138	200
201	Less PBP Clinic Laboratory Services - Program only charges (line 61)				201
202	Net charges (line 200 minus line 201)		202,525,190		202

COMPUTATION OF INPATIENT OPERATING COST		PROVIDER CCN: 11-0028	PERIOD: FROM: 01/01/2021 TO: 12/31/2021	WORKSHEET D-3	
Check Applicable Boxes:	<input type="checkbox"/> Title V - O/P <input type="checkbox"/> Title XVIII, PART A <input checked="" type="checkbox"/> Title XIX - I/P	<input checked="" type="checkbox"/> Hospital <input type="checkbox"/> IPF <input type="checkbox"/> IRF <input type="checkbox"/> Subprovider (Other)	<input type="checkbox"/> SNF <input type="checkbox"/> NF <input type="checkbox"/> Swing-Bed SNF <input type="checkbox"/> Swing-Bed NF	<input type="checkbox"/> ICF/IID <input type="checkbox"/> PARHM Demonstration <input type="checkbox"/> PARHM CAH Swing-Bed SNF <input type="checkbox"/> Chart Model <input type="checkbox"/> Chart CAH Swing-Bed SNF	<input checked="" type="checkbox"/> PPS <input type="checkbox"/> TEFRA <input type="checkbox"/> Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults and Pediatrics (General Routine Care)		1,584,377		30
31	Intensive Care Unit		4,977,026		31
31.01	02060NEURO INTENSIVE CARE UNIT		104,000		31.01
32	Coronary Care Unit				32
33	Burn Intensive Care Unit				33
34	Surgical Intensive Care Unit				34
35	Other Special Care (specify)				35
40	Subprovider - IPF				40
41	Subprovider - IRF				41
42	Subprovider (specify)				42
43	Nursery		92,909		43
ANCILLARY SERVICE COST CENTERS					
50	Operating Room	0.313616	2,370,963	743,572	50
51	Recovery Room				51
52	Labor Room and Delivery Room	1.292925	38,592	49,897	52
53	Anesthesiology	0.064781	157,382	10,195	53
54	Radiology-Diagnostic	0.173856	2,257,492	392,479	54
55	Radiology-Therapeutic				55
56	Radioisotope				56
57	Computed Tomography (CT) Scan	0.026802	2,423,904	64,965	57
58	Magnetic Resonance Imaging (MRI)	0.054231			58
59	Cardiac Catheterization	0.144768			59
60	Laboratory	0.139796	5,182,610	724,508	60
61	PBP Clinical Laboratory Services-Program Only				61
62	Whole Blood & Packed Red Blood Cells				62
63	Blood Storing, Processing, & Trans.				63
64	Intravenous Therapy	0.067724			64
65	Respiratory Therapy	0.190323	1,604,662	305,404	65
66	Physical Therapy	0.380333	915,263	348,105	66
67	Occupational Therapy				67
68	Speech Pathology				68
69	Electrocardiology	0.079732	1,710,437	136,377	69
70	Electroencephalography				70
71	Medical Supplies Charged to Patients	0.181395	7,399,823	1,342,291	71
72	Implantable Devices Charged to Patients	0.534358	89,669	47,915	72
73	Drugs Charged to Patients	0.168173	9,417,608	1,583,787	73
74	Renal Dialysis				74
75	ASC (Non-Distinct Part)				75
76	Other Ancillary (specify)				76
76.97	07697CARDIAC REHABILITATION	0.545560			76.97
OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic (RHC)				88
89	Federally Qualified Health Center (FQHC)				89
90	Clinic	0.853728	13,616	11,624	90
91	Emergency	0.603146	1,018,270	614,165	91
92	Observation Beds	0.554390	467,030	258,917	92
93	Other Outpatient Service (specify)				93
OTHER REIMBURSABLE COST CENTERS					
94	Home Program Dialysis				94
95	Ambulance Services				95
96	Durable Medical Equipment-Rented				96
97	Durable Medical Equipment-Sold				97
98	Other Reimbursable (specify)				98
99	Outpatient Rehabilitation Provider (specify)				99
100	Intern-Resident Service (not appvd. tchnng. prgm.)				100
101	Home Health Agency				101
101.01					101
101.02					101
200	Total (sum of lines 50 through 94 and 96 through 98)		35,067,321	6,634,201	200
201	Less PBP Clinic Laboratory Services - Program only charges (line 61)				201
202	Net charges (line 200 minus line 201)		35,067,321		202