

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

PROVIDER CCN:

PERIOD:

WORKSHEET D

11-0111

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

PART I

Check Title V
 Applicable Title XVIII
 Boxes: Title XIX

Hospital
 PARHM Demonstration
 Chart Model

PPS
 TEFRA

		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)	328,601	32,269	296,332	2,872	103	652	67,273	30
31	Intensive Care Unit								31
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
44	Skilled Nursing Facility								44
45	Nursing Facility								45
46	Other Long Term Care								46
200	Total	328,601		296,332	2,872		652	67,273	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		PROVIDER CCN: 11-0111	PERIOD: FROM: 01/01/2021 TO: 12/31/2021	WORKSHEET D PART II
Check Applicable Boxes:	<input type="checkbox"/> Title V <input checked="" type="checkbox"/> Title XVIII <input type="checkbox"/> Title XIX	<input checked="" type="checkbox"/> Hospital <input type="checkbox"/> PARHM Demonstration <input type="checkbox"/> Chart Model	<input checked="" type="checkbox"/> PPS <input type="checkbox"/> TEFRA	

		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)	
COST CENTER DESCRIPTIONS		1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	238,087	7,595,268	0	160,806	5,041	50
51	Recovery Room	11,353	1,092,850	0	24,797	258	51
53	Anesthesiology	270	787,364	0	29,914	10	53
54	Radiology-Diagnostic	164,922	17,250,118	0	454,301	4,344	54
60	Laboratory	76,491	8,715,335	0	347,931	3,054	60
65	Respiratory Therapy	24,624	3,447,941	0	122,340	874	65
66	Physical Therapy	16,888	1,422,910	0	143,158	1,699	66
71	Medical Supplies Charged to Patients	51,244	7,374,835	0	438,797	3,049	71
72	Implantable Devices Charged to Patients	24,422	2,937,042	0	224,379	1,866	72
73	Drugs Charged to Patients	65,426	10,393,725	0	708,425	4,460	73
76	Other Ancillary (specify)	13,832	129,964	0			76
OUTPATIENT SERVICE COST CENTERS							
91	Emergency	280,587	15,145,310	0	275,466	5,103	91
92	Observation Beds	70,988	622,720	0	59,423	6,774	92
200	Total (sum of lines 50 through 199)	1,039,134	76,915,382		2,989,737	36,532	200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS-THROUGH COSTS

PROVIDER CCN:
11-0111

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

WORKSHEET D
PART III

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											
		Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	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)	
	COST CENTER DESCRIPTIONS	1A	1	2A	2	3	4	5	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS												
30	Adults and Pediatrics (General Routine Care)								2,872		652		30
31	Intensive Care Unit												31
33	Burn Intensive Care Unit												33
35	Other Special Care (specify)												35
41	Subprovider - IRF												41
43	Nursery												43
200	Total								2,872		652		200

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS-THROUGH COSTS				PROVIDER CCN: 11-0111	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	7,595,268			160,806		1,464,922		50
51	Recovery Room	1,092,850			24,797		185,326		51
52	Labor Room and Delivery Room								52
53	Anesthesiology	787,364			29,914		119,029		53
54	Radiology-Diagnostic	17,250,118			454,301		2,553,013		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	8,715,335			347,931		892,106		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	3,447,941			122,340		492,467		65
66	Physical Therapy	1,422,910			143,158		12,052		66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged to Patients	7,374,835			438,797		908,201		71
72	Implantable Devices Charged to Patients	2,937,042			224,379		551,021		72
73	Drugs Charged to Patients	10,393,725			708,425		1,292,042		73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)	129,964					31,488		76
OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency	15,145,310			275,466		1,569,556		91
92	Observation Beds	622,720			59,423		240,227		92
93	Other Outpatient Service (specify)								93
200	Total (sum of lines 50 through 199)	76,915,382			2,989,737		10,311,450		200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

PROVIDER CCN:
11-0111

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 checked="" 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 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	0.408000	1,464,922		597,688			50
51	Recovery Room	0.373378	185,326		69,197			51
52	Labor Room and Delivery Room							52
53	Anesthesiology	0.009351	119,029		1,113			53
54	Radiology-Diagnostic	0.108681	2,553,013		277,464			54
60	Laboratory	0.190384	892,106		169,843			60
65	Respiratory Therapy	0.169202	492,467		83,326			65
66	Physical Therapy	0.166505	12,052		2,007			66
71	Medical Supplies Charged to Patients	0.253481	908,201		230,212			71
72	Implantable Devices Charged to Patients	0.303996	551,021		167,508			72
73	Drugs Charged to Patients	0.155755	1,292,042		201,242			73
76	Other Ancillary (specify)	0.673917	31,488		21,220			76
OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.270595	1,569,556		424,714			91
92	Observation Beds	1.444654	240,227		347,045			92
200	Subtotal (see instructions)		10,311,450		2,592,579			200
201	Less PBP Clinic Lab. Services - Program Only Charges							201
202	Net Charges (line 200 - line 201)		10,311,450		2,592,579			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

PROVIDER CCN:
11-0111

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	0.408000		212,917		86,870	50
51	Recovery Room	0.373378		38,260		14,285	51
53	Anesthesiology	0.009351		23,764		222	53
54	Radiology-Diagnostic	0.108681		726,390		78,945	54
60	Laboratory	0.190384		59,258		11,282	60
65	Respiratory Therapy	0.169202		120,959		20,467	65
71	Medical Supplies Charged to Patients	0.253481		297,463		75,401	71
72	Implantable Devices Charged to Patients	0.303996		5,534		1,682	72
73	Drugs Charged to Patients	0.155755		128,995		20,092	73
OUTPATIENT SERVICE COST CENTERS							
91	Emergency	0.270595		870,117		235,449	91
92	Observation Beds	1.444654		3,676		5,311	92
200	Subtotal (see instructions)			2,487,333		550,006	200
201	Less PBP Clinic Lab. Services - Program Only Charges						201
202	Net Charges (line 200 - line 201)			2,487,333		550,006	202

COMPUTATION OF INPATIENT OPERATING COST		PROVIDER CCN: 11-0111	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		
INPATIENT DAYS		1
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,524
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,872
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)	2,184
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,652
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)	652
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).	556
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	248
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)	4,164,307
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	408,936
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)	408,936
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,755,371
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)	3,755,371

COMPUTATION OF INPATIENT OPERATING COST		PROVIDER CCN: 11-0111	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)		1,308	38
39	Program general inpatient routine service cost (line 9 x line 38)		852,542	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)		852,542	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					43
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)		685,463	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)		1,538,005	49	

PASS-THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)		67,273	50
51	Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV)		36,532	51
52	Total Program excludable cost (sum of lines 50 and 51)		103,805	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)		1,434,200	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
	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	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			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)		137,632	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)		137,632	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: 11-0111	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)	688	87
88	Adjusted general inpatient routine cost per diem (line 27 + line 2)	1,308	88
89	Observation bed cost (line 87 x line 88) (see instructions)	899,615	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					328,601	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: 11-0111	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)	4,524	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,872	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)	2,184	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,652	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)	247	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)		15
16	Nursery days (title V or XIX only)		16
SWING BED ADJUSTMENT			
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	248	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)	4,164,307	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	408,936	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)	408,936	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,755,371	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)	3,755,371	37

COMPUTATION OF INPATIENT OPERATING COST			PROVIDER CCN: 11-0111	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)				1,308	38
39	Program general inpatient routine service cost (line 9 x line 38)				322,972	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)				322,972	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					43
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)				252,842	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)				575,814	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: 11-0111	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)	688	87
88	Adjusted general inpatient routine cost per diem (line 27 + line 2)	1,308	88
89	Observation bed cost (line 87 x line 88) (see instructions)	899,615	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				328,601	90
91	Nursing Program cost					91
92	Allied Health cost					92
93	All other Medical Education					93

COMPUTATION OF INPATIENT OPERATING COST		PROVIDER CCN: 11-0111	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)		495,274		30
31	Intensive Care Unit				31
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	0.408000	160,806	65,609	50
51	Recovery Room	0.373378	24,797	9,259	51
52	Labor Room and Delivery Room				52
53	Anesthesiology	0.009351	29,914	280	53
54	Radiology-Diagnostic	0.108681	454,301	49,374	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	0.190384	347,931	66,240	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	0.169202	122,340	20,700	65
66	Physical Therapy	0.166505	143,158	23,837	66
67	Occupational Therapy				67
68	Speech Pathology				68
69	Electrocardiology				69
70	Electroencephalography				70
71	Medical Supplies Charged to Patients	0.253481	438,797	111,227	71
72	Implantable Devices Charged to Patients	0.303996	224,379	68,210	72
73	Drugs Charged to Patients	0.155755	708,425	110,341	73
74	Renal Dialysis				74
75	ASC (Non-Distinct Part)				75
76	Other Ancillary (specify)	0.673917			76
OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic (RHC)				88
89	Federally Qualified Health Center (FQHC)				89
90	Clinic				90
91	Emergency	0.270595	275,466	74,540	91
92	Observation Beds	1.444654	59,423	85,846	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
200	Total (sum of lines 50 through 94 and 96 through 98)		2,989,737	685,463	200
201	Less PBP Clinic Laboratory Services - Program only charges (line 61)				201
202	Net charges (line 200 minus line 201)		2,989,737		202

COMPUTATION OF INPATIENT OPERATING COST		PROVIDER CCN: 11-0111	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)		191,599		30
31	Intensive Care Unit				31
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	0.408000	71,470	29,160	50
51	Recovery Room	0.373378	10,926	4,080	51
52	Labor Room and Delivery Room				52
53	Anesthesiology	0.009351	13,326	125	53
54	Radiology-Diagnostic	0.108681	90,942	9,884	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	0.190384	107,966	20,555	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	0.169202	30,413	5,146	65
66	Physical Therapy	0.166505	65,500	10,906	66
67	Occupational Therapy				67
68	Speech Pathology				68
69	Electrocardiology				69
70	Electroencephalography				70
71	Medical Supplies Charged to Patients	0.253481	305,282	77,383	71
72	Implantable Devices Charged to Patients	0.303996	68,824	20,922	72
73	Drugs Charged to Patients	0.155755	264,123	41,138	73
74	Renal Dialysis				74
75	ASC (Non-Distinct Part)				75
76	Other Ancillary (specify)	0.673917			76
OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic (RHC)				88
89	Federally Qualified Health Center (FQHC)				89
90	Clinic				90
91	Emergency	0.270595	65,765	17,796	91
92	Observation Beds	1.444654	10,900	15,747	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
200	Total (sum of lines 50 through 94 and 96 through 98)		1,105,437	252,842	200
201	Less PBP Clinic Laboratory Services - Program only charges (line 61)				201
202	Net charges (line 200 minus line 201)		1,105,437		202