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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1329	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/31/2022 10:24 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/31/2022 Time: 10:24 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION 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 MARGARET MARY COMMUNITY HOSPITAL (15-1329) 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	Craig Polkow		Y	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	Craig Polkow			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-876,664	-2,840,669	0	-51,755	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	-4,867	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		11,268		0	10.00
200.00	Total	0	-881,531	-2,829,401	0	-51,755	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 10:24 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 321 MITCHELL	PO Box:			1.00
2.00	City: BATESVILLE	State: IN	Zip Code: 47006-	County: RIPLEY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	MARGARET MARY COMMUNITY HOSPITAL	151329	99915	1	01/07/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MARGARET MARY COMMUNITY HOSPITAL	15Z329	99915		09/10/2020	N	O	O	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	MARGARET MARY COMMUNITY HOSPITAL	157143	99915		03/01/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	MARGARET MARY COMMUNITY HOSPITAL	151551	99915		12/31/2003				14.00
15.00	Hospital-Based Health Clinic - RHC	MARGARET MARY COMMUNITY HOSPITAL	158511	99915		09/03/2013	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2021	12/31/2021	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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)	N	N		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.	0			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2022 10:24 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.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 10:24 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 adjustement? Enter "Y" for yes or "N" for no in column 2.	N			60.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 10:24 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	0.00	0.000000	66.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2022 10:24 am

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 10:24 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	3.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				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:	414,191	0	0		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: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2022 10:24 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)	N		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:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1329	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 10:24 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2022 10:24 am

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/28/2022	Y	04/28/2022	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2022 10:24 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.	Y	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.	Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMITH@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1329	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/31/2022 10:24 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.	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: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2022 10:24 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	18	6,570	123,720.00	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)		18	6,570	123,720.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,555	10,560.00	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)		25	9,125	134,280.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2022 10:24 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)	1,869	13	5,001			1.00
2.00	HMO and other (see instructions)	941	238				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	149	0	149			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	5			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,018	13	5,155			7.00
8.00	INTENSIVE CARE UNIT	165	1	440			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		0	825			13.00
14.00	Total (see instructions)	2,183	14	6,420	0.00	627.25	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	11.97	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,380	2,709	10,452	0.00	19.64	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	658.86	27.00
28.00	Observation Bed Days		409	1,738			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2022 10:24 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	505	4	1,555	1.00
2.00	HMO and other (see instructions)			213	98		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	505	4	1,555	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					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-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/31/2022 10:24 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			112 N. BUCKEYE ST.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	OSGOOD		IN	47037	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	16:30	08:00	11.00

	1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0 13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County						2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/31/2022 10:24 am

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	06:00	08:00	12:00		11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/31/2022 10:24 am

Hospice I

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	8,000	93	387	8,480	11.00
12.00	Hospice Inpatient Respite Care	4	0	4	8	12.00
13.00	Hospice General Inpatient Care	0	0	0	0	13.00
14.00	Total Hospice Days	8,004	93	391	8,488	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-10 | Date/Time Prepared: 5/31/2022 10:24 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)	0.304121	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,812,871	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	28,335,776	6.00
7.00	Medicaid cost (line 1 times line 6)	8,617,505	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)	2,804,634	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)	2,804,634	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)	559,717	1,077,444	1,637,161	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	170,222	1,077,444	1,247,666	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)	170,222	1,077,444	1,247,666	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)	5,745,593	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	431,577	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	663,964	27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,081,629	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,777,817	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,025,483	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,830,117	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/31/2022 10:24 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,802,021	2,802,021	-46,711	2,755,310	1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG		841,420	841,420	46,711	888,131	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		4,818,762	4,818,762	-611,982	4,206,780	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0	0	611,982	611,982	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	218,101	14,220,862	14,438,963	0	14,438,963	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,809,327	11,872,681	19,682,008	368,374	20,050,382	5.00
7.00	00700	OPERATION OF PLANT	0	1,467,146	1,467,146	-164	1,466,982	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	230,243	230,243	0	230,243	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	542,894	19,405	562,299	0	562,299	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	133,097	67,033	200,130	-13,548	186,582	8.00
9.00	00900	HOUSEKEEPING	920,195	339,711	1,259,906	-4,050	1,255,856	9.00
10.00	01000	DIETARY	476,037	538,604	1,014,641	-866,576	148,065	10.00
11.00	01100	CAFETERIA	0	0	0	826,279	826,279	11.00
13.00	01300	NURSING ADMINISTRATION	1,533,539	186,925	1,720,464	-102,823	1,617,641	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	597,953	4,253,939	4,851,892	-27,897	4,823,995	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	802,702	65,627	868,329	0	868,329	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,344,574	1,240,297	3,584,871	379,136	3,964,007	30.00
31.00	03100	INTENSIVE CARE UNIT	357,116	36,037	393,153	-31,160	361,993	31.00
43.00	04300	NURSERY	0	5,627	5,627	682,042	687,669	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,680,814	3,728,584	5,409,398	-3,167,758	2,241,640	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,352,568	240,970	1,593,538	-1,459,952	133,586	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,261,509	9,352,299	12,613,808	-349,509	12,264,299	54.00
60.00	06000	LABORATORY	1,806,063	3,179,565	4,985,628	-71,293	4,914,335	60.00
65.00	06500	RESPIRATORY THERAPY	669,867	292,807	962,674	-52,107	910,567	65.00
66.00	06600	PHYSICAL THERAPY	1,057,953	48,406	1,106,359	-10,956	1,095,403	66.00
67.00	06700	OCCUPATIONAL THERAPY	337,095	15,576	352,671	-11,680	340,991	67.00
68.00	06800	SPEECH PATHOLOGY	144,747	1,740	146,487	-711	145,776	68.00
69.00	06900	ELECTROCARDIOLOGY	625,212	240,821	866,033	-27,675	838,358	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,492,724	3,492,724	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,519,397	1,519,397	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,414,768	138,815	1,553,583	0	1,553,583	88.00
90.00	09000	CLINIC	2,527,652	961,086	3,488,738	-228,340	3,260,398	90.00
90.01	09001	WOUND CLINC	349,812	210,749	560,561	-205,902	354,659	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	2,243,777	2,825,017	5,068,794	-266,339	4,802,455	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	685,635	292,871	978,506	0	978,506	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,893,007	64,535,646	98,428,653	369,512	98,798,165	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,389,488	2,782,650	14,172,138	0	14,172,138	192.00
192.01	19201	PEDIATRICS	340,003	32,598	372,601	0	372,601	192.01
192.02	19202	BROOKVILLE	120,892	0	120,892	0	120,892	192.02
192.03	19203	RADIOLOGY - OSGOOD	99,779	592	100,371	0	100,371	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	395,370	725,366	1,120,736	-369,512	751,224	194.00
194.01	07951	COMMUNITY BENEFITS	574,348	222,090	796,438	0	796,438	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	15,160	201,369	216,529	0	216,529	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	198,828	22,389	221,217	0	221,217	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	196,695	95,295	291,990	0	291,990	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	47,223,570	68,617,995	115,841,565	0	115,841,565	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/31/2022 10:24 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-669,621	2,085,689		1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	0	888,131		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-13,472	4,193,308		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	611,982		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	154,452	14,593,415		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,598,843	15,451,539		5.00
7.00	00700	OPERATION OF PLANT	-40,959	1,426,023		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	230,243		7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	562,299		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	186,582		8.00
9.00	00900	HOUSEKEEPING	0	1,255,856		9.00
10.00	01000	DIETARY	0	148,065		10.00
11.00	01100	CAFETERIA	-225,170	601,109		11.00
13.00	01300	NURSING ADMINISTRATION	-27,000	1,590,641		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	0	4,823,995		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,973	862,356		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-758,485	3,205,522		30.00
31.00	03100	INTENSIVE CARE UNIT	0	361,993		31.00
43.00	04300	NURSERY	0	687,669		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-113,000	2,128,640		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	133,586		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,416,128	10,848,171		54.00
60.00	06000	LABORATORY	0	4,914,335		60.00
65.00	06500	RESPIRATORY THERAPY	0	910,567		65.00
66.00	06600	PHYSICAL THERAPY	-17,895	1,077,508		66.00
67.00	06700	OCCUPATIONAL THERAPY	-1,950	339,041		67.00
68.00	06800	SPEECH PATHOLOGY	0	145,776		68.00
69.00	06900	ELECTROCARDIOLOGY	-69,438	768,920		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,492,724		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,519,397		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,553,583		88.00
90.00	09000	CLINIC	-1,948,847	1,311,551		90.00
90.01	09001	WOUND CLINC	-49,247	305,412		90.01
90.02	09002	BEHAVIORAL HEALTH	83,765	83,765		90.02
91.00	09100	EMERGENCY	-1,553,078	3,249,377		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	978,506		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,270,889	87,527,276		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	37,856	14,209,994		192.00
192.01	19201	PEDIATRICS	0	372,601		192.01
192.02	19202	BROOKVILLE	231,924	352,816		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	100,371		192.03
192.04	19204	ENT	0	0		192.04
194.00	07950	COMMUNITY RELATIONS	-62	751,162		194.00
194.01	07951	COMMUNITY BENEFITS	0	796,438		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0		194.02
194.03	07953	EMS	0	216,529		194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	221,217		194.04
194.05	07955	MMHCB RHC	81,017	81,017		194.05
194.06	07956	FOUNDATION	-17,632	274,358		194.06
194.07	07957	FQHC	0	0		194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	-10,937,786	104,903,779		200.00

RECLASSIFICATIONS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/31/2022 10:24 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	387,670	438,609		1.00
	0		387,670	438,609		
	B - OB RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	586,203	45,664		1.00
2.00	NURSERY	43.00	635,166	49,478		2.00
	0		1,221,369	95,142		
	C - COMMUNITY RELATIONS					
1.00	ADMINISTRATIVE & GENERAL	5.00	138,380	231,132		1.00
	0		138,380	231,132		
	D - IMPLANTABLE SUPPLIES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,519,397		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	1,519,397		
	E - OFFSITE BUILDING DEPR RECLASS					
1.00	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	611,982		1.00
	0		0	611,982		
	F - CENTRAL SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,492,724		1.00
2.00		0.00	0	0		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
	0		0	3,492,724		
	G - DEPRECIATION RECLASS					
1.00	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	46,711		1.00
	0		0	46,711		
500.00	Grand Total: Increases		1,747,419	6,435,697		500.00

RECLASSIFICATIONS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/31/2022 10:24 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	387,670	438,609	0		1.00
	0		387,670	438,609			
	B - OB RECLASS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1,221,369	95,142	0		1.00
2.00		0.00	0	0	0		2.00
	0		1,221,369	95,142			
	C - COMMUNITY RELATIONS						
1.00	COMMUNITY RELATIONS	194.00	138,380	231,132	0		1.00
	0		138,380	231,132			
	D - IMPLANTABLE SUPPLIES RECLASS						
1.00	OPERATING ROOM	50.00	0	1,485,660	0		1.00
2.00	CLINIC	90.00	0	625	0		2.00
3.00	WOUND CLINC	90.01	0	33,112	0		3.00
	0		0	1,519,397			
	E - OFFSITE BUILDING DEPR RECLASS						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	611,982	9		1.00
	0		0	611,982			
	F - CENTRAL SUPPLY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,138	0		1.00
2.00	OPERATION OF PLANT	7.00	0	164	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	13,548	0		3.00
4.00	HOUSEKEEPING	9.00	0	4,050	0		4.00
5.00	DIETARY	10.00	0	40,297	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	102,823	0		6.00
7.00	PHARMACY	15.00	0	27,897	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	252,731	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	31,160	0		9.00
10.00	NURSERY	43.00	0	2,602	0		10.00
11.00	OPERATING ROOM	50.00	0	1,682,098	0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	143,441	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	349,509	0		13.00
14.00	LABORATORY	60.00	0	71,293	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	52,107	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	10,956	0		16.00
17.00	OCCUPATIONAL THERAPY	67.00	0	11,680	0		17.00
18.00	SPEECH PATHOLOGY	68.00	0	711	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	27,675	0		19.00
20.00	CLINIC	90.00	0	227,715	0		20.00
21.00	WOUND CLINC	90.01	0	172,790	0		21.00
22.00	EMERGENCY	91.00	0	266,339	0		22.00
	0		0	3,492,724			
	G - DEPRECIATION RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	46,711	9		1.00
	0		0	46,711			
500.00	Grand Total: Decreases		1,747,419	6,435,697			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2022 10:24 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,798,684	0	0	0	0	1.00
2.00	Land Improvements	278,583	0	0	0	0	2.00
3.00	Buildings and Fixtures	80,302,549	881,462	0	881,462	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	5,245,768	17,307	0	17,307	0	5.00
6.00	Movable Equipment	62,579,774	2,929,933	0	2,929,933	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	154,205,358	3,828,702	0	3,828,702	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	154,205,358	3,828,702	0	3,828,702	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	5,798,684	0	1.00
2.00	Land Improvements	278,583	0	2.00
3.00	Buildings and Fixtures	81,184,011	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	5,263,075	0	5.00
6.00	Movable Equipment	65,509,707	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	158,034,060	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	158,034,060	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II | Date/Time Prepared: 5/31/2022 10:24 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	NEW CAP REL COSTS-BLDG & FIXT	1,961,664	0	840,357	0	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	841,420	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,818,762	0	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	7,621,846	0	840,357	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,802,021	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	841,420	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	4,818,762	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	2.01
3.00	Total (sum of lines 1-2)	0	8,462,203	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2022 10:24 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	NEW CAP REL COSTS-BLDG & FIXT	64,236,916	0	64,236,916	0.408244	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	20,418,269	0	20,418,269	0.129764	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	72,694,018	0	72,694,018	0.461992	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	157,349,203	0	157,349,203	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,914,953	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	888,131	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	4,193,308	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	611,982	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	7,608,374	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	170,736	0	0	0	2,085,689	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	0	888,131	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,193,308	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	611,982	2.01
3.00	Total (sum of lines 1-2)	170,736	0	0	0	7,779,110	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/31/2022 10:24 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-OFFSITE BLDG (chapter 2)		0	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	2.01
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	-5,816,032			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-224,022	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		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	B	-1,148	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-OFFSITE BLDG		0	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	26.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/31/2022 10:24 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-13,472	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHER INCOME	B	154,452	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
35.00	OTHER OPERATING - OTHER OPER. - MISC	B	-40,908	OPERATION OF PLANT	7.00	0	35.00
37.00	OTHER OPERATING - OTHER OPER. - MEDI	B	-5,973	MEDICAL RECORDS & LIBRARY	16.00	0	37.00
38.00	OTHER OPERATING - OTHER OPER. - PHYS	B	-17,895	PHYSICAL THERAPY	66.00	0	38.00
39.00	OTHER OPERATING - OTHER OPER. - OCCU	B	-1,950	OCCUPATIONAL THERAPY	67.00	0	39.00
40.00	OTHER OPERATING - OTHER OPER. - OUTP	B	-115,725	CLINIC	90.00	0	40.00
43.00	INTEREST OFFSET	A	-669,621	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	43.00
44.00	LOBBYING EXPENSE	A	-7,296	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	MEDICAL STAFF RETENTION COST	A	-91,282	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	HAF	A	-4,497,563	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	TELEPHONE & TV OFFSET	A	-2,482	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	BOUTIQUE OFFSET	A	-237	RADIOLOGY-DIAGNOSTIC	54.00	0	45.03
45.04	HOSPITALIST OFFSET	A	-3,229	ADULTS & PEDIATRICS	30.00	11	45.04
45.05	PLANT OPERATION-GRANTS-MMHF TO MMH	A	-51	OPERATION OF PLANT	7.00	0	45.05
45.07	MARKETING-GRANTS-MMHF TO MMH	A	-62	COMMUNITY RELATIONS	194.00	0	45.07
45.08	FOUNDATION EXPENSE	A	-17,632	FOUNDATION	194.06	0	45.08
45.09	BEHAVIORAL HEALTH	A	83,765	BEHAVIORAL HEALTH	90.02	0	45.09
45.10	PHYSICIAN CLINIC	A	37,856	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.10
45.11	BROOKVILLE	A	231,924	BROOKVILLE	192.02	0	45.11
45.12	MMHCB RHC	A	81,017	MMHCB RHC	194.05	0	45.12
45.13	BENEFITS SCREENING	B	-220	ADMINISTRATIVE & GENERAL	5.00	0	45.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,937,786				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2022 10:24 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	13.00	NURSING ADMINISTRATION	27,000	27,000	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	871,756	755,256	116,500	0	0	2.00
3.00	50.00	OPERATING ROOM	168,000	113,000	55,000	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	1,473,891	1,415,891	58,000	0	0	4.00
5.00	60.00	LABORATORY	72,450	0	72,450	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	109,438	69,438	40,000	0	0	6.00
7.00	90.00	CLINIC	1,868,122	1,833,122	35,000	0	0	7.00
8.00	90.01	WOUND CLINC	49,247	49,247	0	0	0	8.00
9.00	91.00	EMERGENCY	3,082,729	1,553,078	1,529,650	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			7,722,633	5,816,032	1,906,600		0	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	13.00	NURSING ADMINISTRATION	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	90.01	WOUND CLINC	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	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	13.00	NURSING ADMINISTRATION	0	0	0	27,000		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	755,256		2.00
3.00	50.00	OPERATING ROOM	0	0	0	113,000		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,415,891		4.00
5.00	60.00	LABORATORY	0	0	0	0		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	69,438		6.00
7.00	90.00	CLINIC	0	0	0	1,833,122		7.00
8.00	90.01	WOUND CLINC	0	0	0	49,247		8.00
9.00	91.00	EMERGENCY	0	0	0	1,553,078		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	5,816,032		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/31/2022 10:24 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,085,689	2,085,689				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	888,131	0	888,131			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	4,193,308			4,193,308		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	611,982			0	611,982	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,593,415	8,734	0	17,560	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,451,539	305,608	0	614,429	0	5.00
7.00	00700	OPERATION OF PLANT	1,426,023	370,347	0	744,590	0	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	230,243	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	562,299	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	186,582	23,184	0	46,611	0	8.00
9.00	00900	HOUSEKEEPING	1,255,856	26,448	0	53,174	0	9.00
10.00	01000	DIETARY	148,065	21,855	0	43,940	0	10.00
11.00	01100	CAFETERIA	601,109	54,534	0	109,642	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,590,641	787	453	1,582	312	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,766	0	19,635	0	14.00
15.00	01500	PHARMACY	4,823,995	7,792	0	15,667	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	862,356	35,737	0	71,849	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,205,522	189,508	0	381,009	0	30.00
31.00	03100	INTENSIVE CARE UNIT	361,993	17,920	0	36,028	0	31.00
43.00	04300	NURSERY	687,669	9,508	0	19,117	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,128,640	57,282	0	115,167	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	133,586	18,165	0	36,521	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,848,171	252,532	0	507,719	0	54.00
60.00	06000	LABORATORY	4,914,335	44,897	0	90,266	0	60.00
65.00	06500	RESPIRATORY THERAPY	910,567	34,331	0	69,022	0	65.00
66.00	06600	PHYSICAL THERAPY	1,077,508	71,887	0	144,529	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	339,041	15,082	0	30,322	0	67.00
68.00	06800	SPEECH PATHOLOGY	145,776	13,779	0	27,702	0	68.00
69.00	06900	ELECTROCARDIOLOGY	768,920	31,092	0	62,512	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,492,724	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,519,397	36,266	0	72,913	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,553,583	0	52,964	0	36,496	88.00
90.00	09000	CLINIC	1,311,551	180,787	0	363,475	0	90.00
90.01	09001	WOUND CLINC	305,412	10,179	0	20,465	0	90.01
90.02	09002	BEHAVIORAL HEALTH	83,765	18,488	0	37,170	0	90.02
91.00	09100	EMERGENCY	3,249,377	115,338	0	231,889	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	978,506	46,484	257	93,456	177	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,527,276	2,028,317	53,674	4,077,961	36,985	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,209,994	0	658,976	0	454,079	192.00
192.01	19201	PEDIATRICS	372,601	29,247	0	58,802	0	192.01
192.02	19202	BROOKVILLE	352,816	0	11,254	0	7,755	192.02
192.03	19203	RADIOLOGY - OSGOOD	100,371	0	3,274	0	2,256	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	751,162	3,909	0	7,859	0	194.00
194.01	07951	COMMUNITY BENEFITS	796,438	17,778	0	35,743	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	216,529	0	0	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	221,217	0	0	0	0	194.04
194.05	07955	MMHCB RHC	81,017	0	4,613	0	3,179	194.05
194.06	07956	FOUNDATION	274,358	5,070	0	10,194	0	194.06
194.07	07957	FQHC	0	1,368	156,340	2,749	107,728	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	104,903,779	2,085,689	888,131	4,193,308	611,982	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/31/2022 10:24 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
			4.00	4A	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,619,709					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,471,904	18,843,480	18,843,480			5.00
7.00	00700	OPERATION OF PLANT	0	2,540,960	556,361	3,097,321		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	230,243	50,413	0	280,656	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	168,851	731,150	160,090	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	41,396	297,773	65,199	51,255	0	8.00
9.00	00900	HOUSEKEEPING	286,200	1,621,678	355,078	58,471	0	9.00
10.00	01000	DIETARY	27,484	241,344	52,844	48,317	0	10.00
11.00	01100	CAFETERIA	120,574	885,859	193,965	120,564	0	11.00
13.00	01300	NURSING ADMINISTRATION	476,963	2,070,738	453,403	1,740	143	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	29,401	6,438	21,591	0	14.00
15.00	01500	PHARMACY	185,976	5,033,430	1,102,105	17,227	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	249,657	1,219,599	267,040	79,007	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	911,533	4,687,572	1,026,377	418,964	0	30.00
31.00	03100	INTENSIVE CARE UNIT	111,071	527,012	115,393	39,617	0	31.00
43.00	04300	NURSERY	197,550	913,844	200,093	21,021	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	522,768	2,823,857	618,303	126,639	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	40,806	229,078	50,158	40,159	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,014,398	12,622,820	2,763,855	558,295	0	54.00
60.00	06000	LABORATORY	561,724	5,611,222	1,228,616	99,258	0	60.00
65.00	06500	RESPIRATORY THERAPY	208,343	1,222,263	267,623	75,898	0	65.00
66.00	06600	PHYSICAL THERAPY	329,046	1,622,970	355,361	158,926	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	104,844	489,289	107,133	33,343	0	67.00
68.00	06800	SPEECH PATHOLOGY	45,019	232,276	50,858	30,462	0	68.00
69.00	06900	ELECTROCARDIOLOGY	194,454	1,056,978	231,433	68,739	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,492,724	764,756	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,628,576	356,588	80,176	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	440,023	2,083,066	456,102	0	16,737	88.00
90.00	09000	CLINIC	786,153	2,641,966	578,477	399,683	0	90.00
90.01	09001	WOUND CLINC	108,799	444,855	97,404	22,504	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	139,423	30,528	40,872	0	90.02
91.00	09100	EMERGENCY	697,862	4,294,466	940,303	254,989	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	213,247	1,332,127	291,679	102,766	81	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,516,645	81,842,039	13,793,976	2,970,483	16,961	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,542,389	18,865,438	4,130,694	0	208,242	192.00
192.01	19201	PEDIATRICS	105,748	566,398	124,017	64,660	0	192.01
192.02	19202	BROOKVILLE	37,600	409,425	89,646	0	3,556	192.02
192.03	19203	RADIOLOGY - OSGOOD	31,033	136,934	29,983	0	1,035	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	79,929	842,859	184,550	8,642	0	194.00
194.01	07951	COMMUNITY BENEFITS	178,634	1,028,593	225,218	39,304	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	4,715	221,244	48,443	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	61,840	283,057	61,977	0	0	194.04
194.05	07955	MMHCB RHC	0	88,809	19,445	0	1,458	194.05
194.06	07956	FOUNDATION	61,176	350,798	76,810	11,209	0	194.06
194.07	07957	FQHC	0	268,185	58,721	3,023	49,404	194.07
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,619,709	104,903,779	18,843,480	3,097,321	280,656	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/31/2022 10:24 am

		Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.02	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	891,240					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	9,140	423,367				8.00
9.00	00900	HOUSEKEEPING	10,427	88,683	2,134,337			9.00
10.00	01000	DIETARY	8,616	371	31,694	383,186		10.00
11.00	01100	CAFETERIA	21,500	1,626	79,084	0	1,302,598	11.00
13.00	01300	NURSING ADMINISTRATION	534	0	1,141	0	27,337	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,850	0	14,163	0	0	14.00
15.00	01500	PHARMACY	3,072	0	11,300	0	30,496	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,089	0	51,825	0	82,502	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	74,712	90,505	274,821	368,430	229,642	30.00
31.00	03100	INTENSIVE CARE UNIT	7,065	4,242	25,987	14,756	23,035	31.00
43.00	04300	NURSERY	3,749	18,593	13,789	0	44,110	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,583	53,052	83,069	0	135,705	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,161	3,120	26,343	0	9,094	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,558	60,671	366,217	0	112,344	54.00
60.00	06000	LABORATORY	17,700	0	65,108	0	159,939	60.00
65.00	06500	RESPIRATORY THERAPY	13,535	3,013	49,785	0	41,060	65.00
66.00	06600	PHYSICAL THERAPY	28,341	4,534	104,248	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,946	19,138	21,871	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,432	2,605	19,982	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,258	7,793	45,089	0	44,110	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,297	7,839	52,592	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	548	0	0	0	88.00
90.00	09000	CLINIC	71,274	15,461	262,173	0	0	90.00
90.01	09001	WOUND CLINC	4,013	139	14,762	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	7,289	0	26,810	0	0	90.02
91.00	09100	EMERGENCY	45,471	30,778	167,261	0	162,444	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	18,453	0	67,877	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	530,065	412,711	1,876,991	383,186	1,101,818	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	253,488	6,784	174,146	0	109,675	192.00
192.01	19201	PEDIATRICS	11,531	0	42,414	0	19,386	192.01
192.02	19202	BROOKVILLE	5,559	0	0	0	0	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	88	0	0	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	1,541	0	5,669	0	16,337	194.00
194.01	07951	COMMUNITY BENEFITS	7,009	0	25,781	0	42,040	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	1,470	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	17	0	0	0	194.04
194.05	07955	MMHCB RHC	2,279	3,767	0	0	0	194.05
194.06	07956	FOUNDATION	1,999	0	7,353	0	11,872	194.06
194.07	07957	FQHC	77,769	0	1,983	0	0	194.07
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)	891,240	423,367	2,134,337	383,186	1,302,598	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/31/2022 10:24 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
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	2,555,036					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	75,443				14.00
15.00	01500	PHARMACY	92,175	0	6,289,805			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,714,062		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	694,393	0	0	1,127,673	8,993,089	30.00
31.00	03100	INTENSIVE CARE UNIT	69,618	0	0	0	826,725	31.00
43.00	04300	NURSERY	133,385	0	0	0	1,348,584	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	126,299	3,989,507	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,553	0	0	0	392,666	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	339,802	0	0	230,045	17,153,607	54.00
60.00	06000	LABORATORY	483,622	0	0	0	7,665,465	60.00
65.00	06500	RESPIRATORY THERAPY	124,170	0	0	0	1,797,347	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,274,380	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	676,720	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	341,615	68.00
69.00	06900	ELECTROCARDIOLOGY	98,992	0	0	13,532	1,578,924	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	75,443	0	0	4,332,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,140,068	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	6,289,805	0	6,289,805	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	2,556,453	88.00
90.00	09000	CLINIC	0	0	0	63,150	4,032,184	90.00
90.01	09001	WOUND CLINC	0	0	0	0	583,677	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	244,922	90.02
91.00	09100	EMERGENCY	491,326	0	0	139,831	6,526,869	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	1,812,983	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,555,036	75,443	6,289,805	1,700,530	75,558,513	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	13,532	23,761,999	192.00
192.01	19201	PEDIATRICS	0	0	0	0	828,406	192.01
192.02	19202	BROOKVILLE	0	0	0	0	508,186	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	168,040	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	0	0	0	1,059,598	194.00
194.01	07951	COMMUNITY BENEFITS	0	0	0	0	1,367,945	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	271,157	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	345,051	194.04
194.05	07955	MMHCB RHC	0	0	0	0	115,758	194.05
194.06	07956	FOUNDATION	0	0	0	0	460,041	194.06
194.07	07957	FQHC	0	0	0	0	459,085	194.07
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,555,036	75,443	6,289,805	1,714,062	104,903,779	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/31/2022 10:24 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT -OFFSITE				7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS				7.02
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
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	8,993,089		30.00
31.00	03100	INTENSIVE CARE UNIT	0	826,725		31.00
43.00	04300	NURSERY	0	1,348,584		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,989,507		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	392,666		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,153,607		54.00
60.00	06000	LABORATORY	0	7,665,465		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,797,347		65.00
66.00	06600	PHYSICAL THERAPY	0	2,274,380		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	676,720		67.00
68.00	06800	SPEECH PATHOLOGY	0	341,615		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,578,924		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,332,923		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,140,068		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,289,805		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	2,556,453		88.00
90.00	09000	CLINIC	0	4,032,184		90.00
90.01	09001	WOUND CLINC	0	583,677		90.01
90.02	09002	BEHAVIORAL HEALTH	0	244,922		90.02
91.00	09100	EMERGENCY	0	6,526,869		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	1,812,983		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	75,558,513		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	23,761,999		192.00
192.01	19201	PEDIATRICS	0	828,406		192.01
192.02	19202	BROOKVILLE	0	508,186		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	168,040		192.03
192.04	19204	ENT	0	0		192.04
194.00	07950	COMMUNITY RELATIONS	0	1,059,598		194.00
194.01	07951	COMMUNITY BENEFITS	0	1,367,945		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0		194.02
194.03	07953	EMS	0	271,157		194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	345,051		194.04
194.05	07955	MMHCB RHC	0	115,758		194.05
194.06	07956	FOUNDATION	0	460,041		194.06
194.07	07957	FQHC	0	459,085		194.07
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	104,903,779		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/31/2022 10:24 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,734	0	17,560	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	305,608	0	614,429	0	5.00
7.00	00700	OPERATION OF PLANT	0	370,347	0	744,590	0	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	23,184	0	46,611	0	8.00
9.00	00900	HOUSEKEEPING	0	26,448	0	53,174	0	9.00
10.00	01000	DIETARY	0	21,855	0	43,940	0	10.00
11.00	01100	CAFETERIA	0	54,534	0	109,642	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	787	453	1,582	312	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,766	0	19,635	0	14.00
15.00	01500	PHARMACY	0	7,792	0	15,667	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,737	0	71,849	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	189,508	0	381,009	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	17,920	0	36,028	0	31.00
43.00	04300	NURSERY	0	9,508	0	19,117	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	57,282	0	115,167	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,165	0	36,521	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	252,532	0	507,719	0	54.00
60.00	06000	LABORATORY	0	44,897	0	90,266	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	34,331	0	69,022	0	65.00
66.00	06600	PHYSICAL THERAPY	0	71,887	0	144,529	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,082	0	30,322	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,779	0	27,702	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	31,092	0	62,512	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	36,266	0	72,913	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	52,964	0	36,496	88.00
90.00	09000	CLINIC	0	180,787	0	363,475	0	90.00
90.01	09001	WOUND CLINC	0	10,179	0	20,465	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	18,488	0	37,170	0	90.02
91.00	09100	EMERGENCY	0	115,338	0	231,889	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	46,484	257	93,456	177	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,028,317	53,674	4,077,961	36,985	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	658,976	0	454,079	192.00
192.01	19201	PEDIATRICS	0	29,247	0	58,802	0	192.01
192.02	19202	BROOKVILLE	0	0	11,254	0	7,755	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	3,274	0	2,256	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	3,909	0	7,859	0	194.00
194.01	07951	COMMUNITY BENEFITS	0	17,778	0	35,743	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	0	194.04
194.05	07955	MMHCB RHC	0	0	4,613	0	3,179	194.05
194.06	07956	FOUNDATION	0	5,070	0	10,194	0	194.06
194.07	07957	FQHC	0	1,368	156,340	2,749	107,728	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,085,689	888,131	4,193,308	611,982	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/31/2022 10:24 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
			2A	4.00	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	26,294	26,294				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	920,037	4,443	924,480			5.00
7.00	00700	OPERATION OF PLANT	1,114,937	0	27,295	1,142,232		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	2,473	0	2,473	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	303	7,854	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	69,795	74	3,199	18,902	0	8.00
9.00	00900	HOUSEKEEPING	79,622	514	17,420	21,563	0	9.00
10.00	01000	DIETARY	65,795	49	2,593	17,818	0	10.00
11.00	01100	CAFETERIA	164,176	217	9,516	44,462	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,134	857	22,244	642	1	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	29,401	0	316	7,962	0	14.00
15.00	01500	PHARMACY	23,459	334	54,069	6,353	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	107,586	449	13,101	29,136	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	570,517	1,638	50,354	154,506	0	30.00
31.00	03100	INTENSIVE CARE UNIT	53,948	200	5,661	14,610	0	31.00
43.00	04300	NURSERY	28,625	355	9,817	7,752	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	172,449	940	30,334	46,702	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	54,686	73	2,461	14,810	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	760,251	1,823	135,594	205,889	0	54.00
60.00	06000	LABORATORY	135,163	1,010	60,276	36,604	0	60.00
65.00	06500	RESPIRATORY THERAPY	103,353	374	13,130	27,990	0	65.00
66.00	06600	PHYSICAL THERAPY	216,416	591	17,434	58,609	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	45,404	188	5,256	12,296	0	67.00
68.00	06800	SPEECH PATHOLOGY	41,481	81	2,495	11,234	0	68.00
69.00	06900	ELECTROCARDIOLOGY	93,604	349	11,354	25,350	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	37,519	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	109,179	0	17,494	29,567	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	89,460	791	22,376	0	147	88.00
90.00	09000	CLINIC	544,262	1,413	28,380	147,395	0	90.00
90.01	09001	WOUND CLINC	30,644	196	4,779	8,299	0	90.01
90.02	09002	BEHAVIORAL HEALTH	55,658	0	1,498	15,073	0	90.02
91.00	09100	EMERGENCY	347,227	1,254	46,131	94,035	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	140,374	383	14,310	37,898	1	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,196,937	18,899	676,733	1,095,457	149	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,113,055	6,387	202,670	0	1,836	192.00
192.01	19201	PEDIATRICS	88,049	190	6,084	23,845	0	192.01
192.02	19202	BROOKVILLE	19,009	68	4,398	0	31	192.02
192.03	19203	RADIOLOGY - OSGOOD	5,530	56	1,471	0	9	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	11,768	144	9,054	3,187	0	194.00
194.01	07951	COMMUNITY BENEFITS	53,521	321	11,049	14,494	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	8	2,377	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	111	3,041	0	0	194.04
194.05	07955	MMHCB RHC	7,792	0	954	0	13	194.05
194.06	07956	FOUNDATION	15,264	110	3,768	4,134	0	194.06
194.07	07957	FQHC	268,185	0	2,881	1,115	435	194.07
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,779,110	26,294	924,480	1,142,232	2,473	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/31/2022 10:24 am

		Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.02	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	8,157					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	84	92,054				8.00
9.00	00900	HOUSEKEEPING	95	19,283	138,497			9.00
10.00	01000	DIETARY	79	81	2,057	88,472		10.00
11.00	01100	CAFETERIA	197	353	5,132	0	224,053	11.00
13.00	01300	NURSING ADMINISTRATION	5	0	74	0	4,702	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	35	0	919	0	0	14.00
15.00	01500	PHARMACY	28	0	733	0	5,245	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	129	0	3,363	0	14,191	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	684	19,680	17,833	85,065	39,499	30.00
31.00	03100	INTENSIVE CARE UNIT	65	922	1,686	3,407	3,962	31.00
43.00	04300	NURSERY	34	4,043	895	0	7,587	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	207	11,535	5,390	0	23,342	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	66	678	1,709	0	1,564	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	911	13,192	23,762	0	19,324	54.00
60.00	06000	LABORATORY	162	0	4,225	0	27,510	60.00
65.00	06500	RESPIRATORY THERAPY	124	655	3,231	0	7,063	65.00
66.00	06600	PHYSICAL THERAPY	259	986	6,765	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	54	4,161	1,419	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	50	567	1,297	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	112	1,694	2,926	0	7,587	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	131	1,704	3,413	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	119	0	0	0	88.00
90.00	09000	CLINIC	652	3,362	17,012	0	0	90.00
90.01	09001	WOUND CLINC	37	30	958	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	67	0	1,740	0	0	90.02
91.00	09100	EMERGENCY	416	6,692	10,854	0	27,941	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	169	0	4,405	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,852	89,737	121,798	88,472	189,517	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,319	1,475	11,300	0	18,865	192.00
192.01	19201	PEDIATRICS	106	0	2,752	0	3,335	192.01
192.02	19202	BROOKVILLE	51	0	0	0	0	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	19	0	0	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	14	0	368	0	2,810	194.00
194.01	07951	COMMUNITY BENEFITS	64	0	1,673	0	7,231	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	253	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	4	0	0	0	194.04
194.05	07955	MMHCB RHC	21	819	0	0	0	194.05
194.06	07956	FOUNDATION	18	0	477	0	2,042	194.06
194.07	07957	FQHC	712	0	129	0	0	194.07
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)	8,157	92,054	138,497	88,472	224,053	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/31/2022 10:24 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
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	31,659					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	38,633				14.00
15.00	01500	PHARMACY	1,142	0	91,363			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	167,955		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,604	0	0	110,496	1,058,876	30.00
31.00	03100	INTENSIVE CARE UNIT	863	0	0	0	85,324	31.00
43.00	04300	NURSERY	1,653	0	0	0	60,761	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	12,376	303,275	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	341	0	0	0	76,388	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,210	0	0	22,541	1,187,497	54.00
60.00	06000	LABORATORY	5,992	0	0	0	270,942	60.00
65.00	06500	RESPIRATORY THERAPY	1,539	0	0	0	157,459	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	301,060	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	68,778	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	57,205	68.00
69.00	06900	ELECTROCARDIOLOGY	1,227	0	0	1,326	145,529	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	38,633	0	0	76,152	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	161,488	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	91,363	0	91,363	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	112,893	88.00
90.00	09000	CLINIC	0	0	0	6,188	748,664	90.00
90.01	09001	WOUND CLINC	0	0	0	0	44,943	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	74,036	90.02
91.00	09100	EMERGENCY	6,088	0	0	13,702	554,340	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	197,540	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,659	38,633	91,363	166,629	5,834,513	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,326	1,359,233	192.00
192.01	19201	PEDIATRICS	0	0	0	0	124,361	192.01
192.02	19202	BROOKVILLE	0	0	0	0	23,557	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	7,085	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	0	0	0	27,345	194.00
194.01	07951	COMMUNITY BENEFITS	0	0	0	0	88,353	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	2,638	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	3,156	194.04
194.05	07955	MMHCB RHC	0	0	0	0	9,599	194.05
194.06	07956	FOUNDATION	0	0	0	0	25,813	194.06
194.07	07957	FQHC	0	0	0	0	273,457	194.07
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,659	38,633	91,363	167,955	7,779,110	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/31/2022 10:24 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT -OFFSITE				7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS				7.02
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
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,058,876		30.00
31.00	03100	INTENSIVE CARE UNIT	0	85,324		31.00
43.00	04300	NURSERY	0	60,761		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	303,275		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	76,388		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,187,497		54.00
60.00	06000	LABORATORY	0	270,942		60.00
65.00	06500	RESPIRATORY THERAPY	0	157,459		65.00
66.00	06600	PHYSICAL THERAPY	0	301,060		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	68,778		67.00
68.00	06800	SPEECH PATHOLOGY	0	57,205		68.00
69.00	06900	ELECTROCARDIOLOGY	0	145,529		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	76,152		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	161,488		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	91,363		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	112,893		88.00
90.00	09000	CLINIC	0	748,664		90.00
90.01	09001	WOUND CLINC	0	44,943		90.01
90.02	09002	BEHAVIORAL HEALTH	0	74,036		90.02
91.00	09100	EMERGENCY	0	554,340		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	197,540		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,834,513		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,359,233		192.00
192.01	19201	PEDIATRICS	0	124,361		192.01
192.02	19202	BROOKVILLE	0	23,557		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	7,085		192.03
192.04	19204	ENT	0	0		192.04
194.00	07950	COMMUNITY RELATIONS	0	27,345		194.00
194.01	07951	COMMUNITY BENEFITS	0	88,353		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0		194.02
194.03	07953	EMS	0	2,638		194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	3,156		194.04
194.05	07955	MMHCB RHC	0	9,599		194.05
194.06	07956	FOUNDATION	0	25,813		194.06
194.07	07957	FQHC	0	273,457		194.07
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,779,110		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 10:24 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	161,664					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	0	86,257				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			161,664			2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT			0	86,257		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	677	0	677	0	47,005,469	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,688	0	23,688	0	7,947,707	5.00
7.00	00700	OPERATION OF PLANT	28,706	0	28,706	0	0	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	542,894	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	1,797	0	1,797	0	133,097	8.00
9.00	00900	HOUSEKEEPING	2,050	0	2,050	0	920,195	9.00
10.00	01000	DIETARY	1,694	0	1,694	0	88,367	10.00
11.00	01100	CAFETERIA	4,227	0	4,227	0	387,670	11.00
13.00	01300	NURSING ADMINISTRATION	61	44	61	44	1,533,539	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	757	0	757	0	0	14.00
15.00	01500	PHARMACY	604	0	604	0	597,953	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,770	0	2,770	0	802,702	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,689	0	14,689	0	2,930,777	30.00
31.00	03100	INTENSIVE CARE UNIT	1,389	0	1,389	0	357,116	31.00
43.00	04300	NURSERY	737	0	737	0	635,166	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,440	0	4,440	0	1,680,814	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,408	0	1,408	0	131,199	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,574	0	19,574	0	3,261,509	54.00
60.00	06000	LABORATORY	3,480	0	3,480	0	1,806,063	60.00
65.00	06500	RESPIRATORY THERAPY	2,661	0	2,661	0	669,867	65.00
66.00	06600	PHYSICAL THERAPY	5,572	0	5,572	0	1,057,953	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,169	0	1,169	0	337,095	67.00
68.00	06800	SPEECH PATHOLOGY	1,068	0	1,068	0	144,747	68.00
69.00	06900	ELECTROCARDIOLOGY	2,410	0	2,410	0	625,212	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,811	0	2,811	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,144	0	5,144	1,414,768	88.00
90.00	09000	CLINIC	14,013	0	14,013	0	2,527,652	90.00
90.01	09001	WOUND CLINC	789	0	789	0	349,812	90.01
90.02	09002	BEHAVIORAL HEALTH	1,433	0	1,433	0	0	90.02
91.00	09100	EMERGENCY	8,940	0	8,940	0	2,243,777	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,603	25	3,603	25	685,635	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	157,217	5,213	157,217	5,213	33,813,286	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	64,001	0	64,001	11,389,488	192.00
192.01	19201	PEDIATRICS	2,267	0	2,267	0	340,003	192.01
192.02	19202	BROOKVILLE	0	1,093	0	1,093	120,892	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	318	0	318	99,779	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	303	0	303	0	256,990	194.00
194.01	07951	COMMUNITY BENEFITS	1,378	0	1,378	0	574,348	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	15,160	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	198,828	194.04
194.05	07955	MMHCB RHC	0	448	0	448	0	194.05
194.06	07956	FOUNDATION	393	0	393	0	196,695	194.06
194.07	07957	FQHC	106	15,184	106	15,184	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,085,689	888,131	4,193,308	611,982	14,619,709	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.901382	10.296335	25.938415	7.094868	0.311021	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					26,294	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 10:24 am

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		1.00	1.01	2.00	2.01	4.00	
205.00	Unit cost multiplier (Wkst. B, Part II)					0.000559	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 10:24 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
			5A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-18,843,480	86,060,299				5.00
7.00	00700	OPERATION OF PLANT	0	2,540,960	108,593			7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	230,243	0	86,257		7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	731,150	0	0	175,225	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	297,773	1,797	0	1,797	8.00
9.00	00900	HOUSEKEEPING	0	1,621,678	2,050	0	2,050	9.00
10.00	01000	DIETARY	0	241,344	1,694	0	1,694	10.00
11.00	01100	CAFETERIA	0	885,859	4,227	0	4,227	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,070,738	61	44	105	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	29,401	757	0	757	14.00
15.00	01500	PHARMACY	0	5,033,430	604	0	604	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,219,599	2,770	0	2,770	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,687,572	14,689	0	14,689	30.00
31.00	03100	INTENSIVE CARE UNIT	0	527,012	1,389	0	1,389	31.00
43.00	04300	NURSERY	0	913,844	737	0	737	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,823,857	4,440	0	4,440	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	229,078	1,408	0	1,408	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,622,820	19,574	0	19,574	54.00
60.00	06000	LABORATORY	0	5,611,222	3,480	0	3,480	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,222,263	2,661	0	2,661	65.00
66.00	06600	PHYSICAL THERAPY	0	1,622,970	5,572	0	5,572	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	489,289	1,169	0	1,169	67.00
68.00	06800	SPEECH PATHOLOGY	0	232,276	1,068	0	1,068	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,056,978	2,410	0	2,410	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,492,724	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,628,576	2,811	0	2,811	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,083,066	0	5,144	0	88.00
90.00	09000	CLINIC	0	2,641,966	14,013	0	14,013	90.00
90.01	09001	WOUND CLINC	0	444,855	789	0	789	90.01
90.02	09002	BEHAVIORAL HEALTH	0	139,423	1,433	0	1,433	90.02
91.00	09100	EMERGENCY	0	4,294,466	8,940	0	8,940	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,332,127	3,603	25	3,628	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-18,843,480	62,998,559	104,146	5,213	104,215	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	18,865,438	0	64,001	49,838	192.00
192.01	19201	PEDIATRICS	0	566,398	2,267	0	2,267	192.01
192.02	19202	BROOKVILLE	0	409,425	0	1,093	1,093	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	136,934	0	318	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	842,859	303	0	303	194.00
194.01	07951	COMMUNITY BENEFITS	0	1,028,593	1,378	0	1,378	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	221,244	0	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	283,057	0	0	0	194.04
194.05	07955	MMHCB RHC	0	88,809	0	448	448	194.05
194.06	07956	FOUNDATION	0	350,798	393	0	393	194.06
194.07	07957	FQHC	0	268,185	106	15,184	15,290	194.07
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)		18,843,480	3,097,321	280,656	891,240	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.218957	28.522290	3.253719	5.086261	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		924,480	1,142,232	2,473	8,157	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 10:24 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
			5A	5.00	7.00	7.01	7.02	
205.00		Unit cost multiplier (Wkst. B, Part II)		0.010742	10.518468	0.028670	0.046552	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 10:24 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	341,402					8.00
9.00	00900	HOUSEKEEPING	71,514	114,079				9.00
10.00	01000	DIETARY	299	1,694	16,723			10.00
11.00	01100	CAFETERIA	1,311	4,227	0	23,920		11.00
13.00	01300	NURSING ADMINISTRATION	0	61	0	502	322,709	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	757	0	0	0	14.00
15.00	01500	PHARMACY	0	604	0	560	11,642	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,770	0	1,515	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	72,982	14,689	16,079	4,217	87,704	30.00
31.00	03100	INTENSIVE CARE UNIT	3,421	1,389	644	423	8,793	31.00
43.00	04300	NURSERY	14,993	737	0	810	16,847	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,781	4,440	0	2,492	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,516	1,408	0	167	3,480	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,925	19,574	0	2,063	42,918	54.00
60.00	06000	LABORATORY	0	3,480	0	2,937	61,083	60.00
65.00	06500	RESPIRATORY THERAPY	2,430	2,661	0	754	15,683	65.00
66.00	06600	PHYSICAL THERAPY	3,656	5,572	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,433	1,169	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,101	1,068	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,284	2,410	0	810	12,503	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,321	2,811	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	442	0	0	0	0	88.00
90.00	09000	CLINIC	12,468	14,013	0	0	0	90.00
90.01	09001	WOUND CLINC	112	789	0	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	1,433	0	0	0	90.02
91.00	09100	EMERGENCY	24,819	8,940	0	2,983	62,056	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	3,628	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	332,808	100,324	16,723	20,233	322,709	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,471	9,308	0	2,014	0	192.00
192.01	19201	PEDIATRICS	0	2,267	0	356	0	192.01
192.02	19202	BROOKVILLE	0	0	0	0	0	192.02
192.03	19203	RADIOLOGY - OSGOOD	71	0	0	0	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	303	0	300	0	194.00
194.01	07951	COMMUNITY BENEFITS	0	1,378	0	772	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	27	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	14	0	0	0	0	194.04
194.05	07955	MMHCB RHC	3,038	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	393	0	218	0	194.06
194.07	07957	FQHC	0	106	0	0	0	194.07
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)	423,367	2,134,337	383,186	1,302,598	2,555,036	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.240084	18.709289	22.913712	54.456438	7.917461	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	92,054	138,497	88,472	224,053	31,659	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.269635	1.214045	5.290438	9.366764	0.098104	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 10:24 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
			8.00	9.00	10.00	11.00	13.00	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 10:24 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (100% MED SUPPLIES)	PHARMACY (100% TO DRUGS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT -OFFSITE					7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS					7.02
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	100				14.00
15.00	01500	PHARMACY	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	760		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	500		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	56		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	102		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	6		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	100	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	28		90.00
90.01	09001	WOUND CLINC	0	0	0		90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	62		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	754		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	6		192.00
192.01	19201	PEDIATRICS	0	0	0		192.01
192.02	19202	BROOKVILLE	0	0	0		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0		192.03
192.04	19204	ENT	0	0	0		192.04
194.00	07950	COMMUNITY RELATIONS	0	0	0		194.00
194.01	07951	COMMUNITY BENEFITS	0	0	0		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0		194.02
194.03	07953	EMS	0	0	0		194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0		194.04
194.05	07955	MMHCB RHC	0	0	0		194.05
194.06	07956	FOUNDATION	0	0	0		194.06
194.07	07957	FQHC	0	0	0		194.07
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)	75,443	6,289,805	1,714,062		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	754.430000	62,898.050000	2,255.344737		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	38,633	91,363	167,955		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	386.330000	913.630000	220.993421		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 10:24 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (100% MED SUPPLIES)	PHARMACY (100% TO DRUGS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			14.00	15.00	16.00		
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/31/2022 10:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,993,089		8,993,089	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	826,725		826,725	0	0	31.00
43.00	04300	NURSERY	1,348,584		1,348,584	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,989,507		3,989,507	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	392,666		392,666	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,153,607		17,153,607	0	0	54.00
60.00	06000	LABORATORY	7,665,465		7,665,465	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,797,347	0	1,797,347	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,274,380	0	2,274,380	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	676,720	0	676,720	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	341,615	0	341,615	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,578,924		1,578,924	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,332,923		4,332,923	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,140,068		2,140,068	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,289,805		6,289,805	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,556,453		2,556,453	0	0	88.00
90.00	09000	CLINIC	4,032,184		4,032,184	0	0	90.00
90.01	09001	WOUND CLINC	583,677		583,677	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	244,922		244,922	0	0	90.02
91.00	09100	EMERGENCY	6,526,869		6,526,869	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,268,872		2,268,872		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,812,983		1,812,983		0	116.00
200.00		Subtotal (see instructions)	77,827,385	0	77,827,385	0	0	200.00
201.00		Less Observation Beds	2,268,872		2,268,872		0	201.00
202.00		Total (see instructions)	75,558,513	0	75,558,513	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/31/2022 10:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,299,199		7,299,199			30.00
31.00	03100	INTENSIVE CARE UNIT	1,062,737		1,062,737			31.00
43.00	04300	NURSERY	2,518,384		2,518,384			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,774,363	7,366,323	9,140,686	0.436456	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	257,536	40,775	298,311	1.316297	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,361,761	88,485,951	90,847,712	0.188817	0.000000	54.00
60.00	06000	LABORATORY	5,319,427	45,086,256	50,405,683	0.152075	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,653,596	1,347,632	4,001,228	0.449199	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	155,390	4,614,030	4,769,420	0.476867	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	122,790	1,007,083	1,129,873	0.598935	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	47,772	601,434	649,206	0.526204	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	367,904	6,142,391	6,510,295	0.242527	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,189,354	12,203,941	16,393,295	0.264311	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	738,560	1,666,084	2,404,644	0.889973	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,137,500	10,791,319	17,928,819	0.350821	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,596,586	1,596,586			88.00
90.00	09000	CLINIC	1,001	6,763,307	6,764,308	0.596097	0.000000	90.00
90.01	09001	WOUND CLINC	0	1,809,203	1,809,203	0.322616	0.000000	90.01
90.02	09002	BEHAVIORAL HEALTH	0	133,729	133,729	1.831480	0.000000	90.02
91.00	09100	EMERGENCY	798,859	16,658,305	17,457,164	0.373879	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	103,205	3,398,603	3,501,808	0.647914	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,826,705	1,826,705			116.00
200.00		Subtotal (see instructions)	36,909,338	211,539,657	248,448,995			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	36,909,338	211,539,657	248,448,995			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/31/2022 10:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CLINC	0.000000		90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/31/2022 10:24 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,993,089		8,993,089	0	8,993,089	30.00
31.00	03100	INTENSIVE CARE UNIT	826,725		826,725	0	826,725	31.00
43.00	04300	NURSERY	1,348,584		1,348,584	0	1,348,584	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,989,507		3,989,507	0	3,989,507	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	392,666		392,666	0	392,666	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,153,607		17,153,607	0	17,153,607	54.00
60.00	06000	LABORATORY	7,665,465		7,665,465	0	7,665,465	60.00
65.00	06500	RESPIRATORY THERAPY	1,797,347	0	1,797,347	0	1,797,347	65.00
66.00	06600	PHYSICAL THERAPY	2,274,380	0	2,274,380	0	2,274,380	66.00
67.00	06700	OCCUPATIONAL THERAPY	676,720	0	676,720	0	676,720	67.00
68.00	06800	SPEECH PATHOLOGY	341,615	0	341,615	0	341,615	68.00
69.00	06900	ELECTROCARDIOLOGY	1,578,924		1,578,924	0	1,578,924	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,332,923		4,332,923	0	4,332,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,140,068		2,140,068	0	2,140,068	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,289,805		6,289,805	0	6,289,805	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,556,453		2,556,453	0	2,556,453	88.00
90.00	09000	CLINIC	4,032,184		4,032,184	0	4,032,184	90.00
90.01	09001	WOUND CLINC	583,677		583,677	0	583,677	90.01
90.02	09002	BEHAVIORAL HEALTH	244,922		244,922	0	244,922	90.02
91.00	09100	EMERGENCY	6,526,869		6,526,869	0	6,526,869	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,268,872		2,268,872		2,268,872	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,812,983		1,812,983		1,812,983	116.00
200.00		Subtotal (see instructions)	77,827,385	0	77,827,385	0	77,827,385	200.00
201.00		Less Observation Beds	2,268,872		2,268,872		2,268,872	201.00
202.00		Total (see instructions)	75,558,513	0	75,558,513	0	75,558,513	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/31/2022 10:24 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,299,199		7,299,199			30.00
31.00	03100	INTENSIVE CARE UNIT	1,062,737		1,062,737			31.00
43.00	04300	NURSERY	2,518,384		2,518,384			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,774,363	7,366,323	9,140,686	0.436456	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	257,536	40,775	298,311	1.316297	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,361,761	88,485,951	90,847,712	0.188817	0.000000	54.00
60.00	06000	LABORATORY	5,319,427	45,086,256	50,405,683	0.152075	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,653,596	1,347,632	4,001,228	0.449199	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	155,390	4,614,030	4,769,420	0.476867	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	122,790	1,007,083	1,129,873	0.598935	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	47,772	601,434	649,206	0.526204	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	367,904	6,142,391	6,510,295	0.242527	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,189,354	12,203,941	16,393,295	0.264311	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	738,560	1,666,084	2,404,644	0.889973	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,137,500	10,791,319	17,928,819	0.350821	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,596,586	1,596,586	1.601200	0.000000	88.00
90.00	09000	CLINIC	1,001	6,763,307	6,764,308	0.596097	0.000000	90.00
90.01	09001	WOUND CLINC	0	1,809,203	1,809,203	0.322616	0.000000	90.01
90.02	09002	BEHAVIORAL HEALTH	0	133,729	133,729	1.831480	0.000000	90.02
91.00	09100	EMERGENCY	798,859	16,658,305	17,457,164	0.373879	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	103,205	3,398,603	3,501,808	0.647914	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,826,705	1,826,705			116.00
200.00		Subtotal (see instructions)	36,909,338	211,539,657	248,448,995			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	36,909,338	211,539,657	248,448,995			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/31/2022 10:24 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CLINC	0.000000		90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/31/2022 10:24 am

Title XVIII | Hospital | Cost

		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	303,275	9,140,686	0.033179	606,031	20,108	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	76,388	298,311	0.256068	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,187,497	90,847,712	0.013071	673,631	8,805	54.00
60.00	06000	LABORATORY	270,942	50,405,683	0.005375	1,499,471	8,060	60.00
65.00	06500	RESPIRATORY THERAPY	157,459	4,001,228	0.039353	1,057,815	41,628	65.00
66.00	06600	PHYSICAL THERAPY	301,060	4,769,420	0.063123	87,446	5,520	66.00
67.00	06700	OCCUPATIONAL THERAPY	68,778	1,129,873	0.060872	69,215	4,213	67.00
68.00	06800	SPEECH PATHOLOGY	57,205	649,206	0.088115	26,691	2,352	68.00
69.00	06900	ELECTROCARDIOLOGY	145,529	6,510,295	0.022354	155,544	3,477	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	76,152	16,393,295	0.004645	1,244,630	5,781	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	161,488	2,404,644	0.067157	458,045	30,761	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	91,363	17,928,819	0.005096	2,292,543	11,683	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	112,893	1,596,586	0.070709	0	0	88.00
90.00	09000	CLINIC	748,664	6,764,308	0.110679	0	0	90.00
90.01	09001	WOUND CLINC	44,943	1,809,203	0.024841	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	74,036	133,729	0.553627	0	0	90.02
91.00	09100	EMERGENCY	554,340	17,457,164	0.031754	104,299	3,312	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	267,144	3,501,808	0.076287	13,980	1,066	92.00
200.00		Total (lines 50 through 199)	4,699,156	235,741,970		8,289,341	146,766	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/31/2022 10:24 am

Title XVIII | Hospital | Cost

		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINC	0	0	0	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/31/2022 10:24 am

Title XVIII | Hospital | Cost

		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	9,140,686	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	298,311	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	90,847,712	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	50,405,683	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,001,228	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,769,420	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,129,873	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	649,206	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,510,295	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	16,393,295	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,404,644	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	17,928,819	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,596,586	0.000000	88.00
90.00	09000	CLINIC	0	0	0	6,764,308	0.000000	90.00
90.01	09001	WOUND CLINC	0	0	0	1,809,203	0.000000	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	133,729	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	17,457,164	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,501,808	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	235,741,970		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/31/2022 10:24 am

Title XVIII | Hospital | Cost

		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	606,031	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	673,631	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,499,471	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,057,815	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	87,446	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	69,215	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	26,691	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	155,544	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,244,630	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	458,045	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,292,543	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINC	0.000000	0	0	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	104,299	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	13,980	0	0	0	92.00
200.00		Total (lines 50 through 199)		8,289,341	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/31/2022 10:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.436456	0	1,467,757	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.316297	0	10,191	641	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188817	0	32,658,698	3,399	0	54.00
60.00	06000	LABORATORY	0.152075	0	13,099,024	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.449199	0	447,584	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.476867	0	1,527,687	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.598935	0	188,410	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.526204	0	73,772	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.242527	0	1,899,234	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.264311	0	2,933,284	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.889973	0	377,389	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.350821	0	3,950,866	634	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.596097	0	2,024,164	0	0	90.00
90.01	09001	WOUND CLINC	0.322616	0	589,922	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	1.831480	0	16,133	0	0	90.02
91.00	09100	EMERGENCY	0.373879	0	4,118,762	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.647914	0	1,083,587	0	0	92.00
200.00		Subtotal (see instructions)		0	66,466,464	4,674	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	66,466,464	4,674	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/31/2022 10:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	640,611	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,414	844		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,166,517	642		54.00
60.00	06000	LABORATORY	1,992,034	0		60.00
65.00	06500	RESPIRATORY THERAPY	201,054	0		65.00
66.00	06600	PHYSICAL THERAPY	728,504	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	112,845	0		67.00
68.00	06800	SPEECH PATHOLOGY	38,819	0		68.00
69.00	06900	ELECTROCARDIOLOGY	460,616	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	775,299	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	335,866	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,386,047	222		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	1,206,598	0		90.00
90.01	09001	WOUND CLINC	190,318	0		90.01
90.02	09002	BEHAVIORAL HEALTH	29,547	0		90.02
91.00	09100	EMERGENCY	1,539,919	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	702,071	0		92.00
200.00		Subtotal (see instructions)	16,520,079	1,708		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	16,520,079	1,708		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/31/2022 10:24 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,893	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,739	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,001	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	149	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	5	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)	1,869	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)	149	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	231.10	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,993,089	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)	1,156	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)	195,668	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,797,421	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)	8,797,421	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)	1,305.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,439,886	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)	2,439,886	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/31/2022 10:24 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	826,725	440	1,878.92	165	310,022	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)	2,818,766	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,568,674	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	194,512	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)	194,512	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)	1,738	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,305.45	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,268,872	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/31/2022 10:24 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,058,876	8,993,089	0.117743	2,268,872	267,144	90.00
91.00	Nursing Program cost	0	8,993,089	0.000000	2,268,872	0	91.00
92.00	Allied health cost	0	8,993,089	0.000000	2,268,872	0	92.00
93.00	All other Medical Education	0	8,993,089	0.000000	2,268,872	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/31/2022 10:24 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,893	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,739	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,001	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	149	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	5	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)	13	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)	825	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	231.10	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,993,089	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)	1,156	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)	195,668	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,797,421	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)	8,797,421	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)	1,305.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	16,971	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)	16,971	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/31/2022 10:24 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,348,584	825	1,634.65	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	826,725	440	1,878.92	1	1,879	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)	28,721	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	47,571	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,738	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,305.45	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,268,872	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/31/2022 10:24 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,058,876	8,993,089	0.117743	2,268,872	267,144	90.00
91.00	Nursing Program cost	0	8,993,089	0.000000	2,268,872	0	91.00
92.00	Allied health cost	0	8,993,089	0.000000	2,268,872	0	92.00
93.00	All other Medical Education	0	8,993,089	0.000000	2,268,872	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/31/2022 10:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,305,484		30.00
31.00	03100	INTENSIVE CARE UNIT		372,161		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.436456	606,031	264,506	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.316297	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188817	673,631	127,193	54.00
60.00	06000	LABORATORY	0.152075	1,499,471	228,032	60.00
65.00	06500	RESPIRATORY THERAPY	0.449199	1,057,815	475,169	65.00
66.00	06600	PHYSICAL THERAPY	0.476867	87,446	41,700	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.598935	69,215	41,455	67.00
68.00	06800	SPEECH PATHOLOGY	0.526204	26,691	14,045	68.00
69.00	06900	ELECTROCARDIOLOGY	0.242527	155,544	37,724	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.264311	1,244,630	328,969	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.889973	458,045	407,648	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.350821	2,292,543	804,272	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.596097	0	0	90.00
90.01	09001	WOUND CLINC	0.322616	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	1.831480	0	0	90.02
91.00	09100	EMERGENCY	0.373879	104,299	38,995	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.647914	13,980	9,058	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,289,341	2,818,766	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)		8,289,341		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3

Component CCN: 15-Z329 | Date/Time Prepared: 5/31/2022 10:24 am

Title XVIII | Swing Beds - SNF | 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.436456	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.316297	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188817	6,690	1,263	54.00
60.00	06000	LABORATORY	0.152075	19,753	3,004	60.00
65.00	06500	RESPIRATORY THERAPY	0.449199	57,439	25,802	65.00
66.00	06600	PHYSICAL THERAPY	0.476867	29,827	14,224	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.598935	29,240	17,513	67.00
68.00	06800	SPEECH PATHOLOGY	0.526204	6,767	3,561	68.00
69.00	06900	ELECTROCARDIOLOGY	0.242527	171	41	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.264311	26,339	6,962	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.889973	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.350821	71,204	24,980	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.596097	0	0	90.00
90.01	09001	WOUND CLINC	0.322616	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	1.831480	0	0	90.02
91.00	09100	EMERGENCY	0.373879	143	53	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.647914	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		247,573	97,403	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		247,573		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/31/2022 10:24 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		7,827		30.00
31.00	03100	INTENSIVE CARE UNIT		758		31.00
43.00	04300	NURSERY		44,510		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.436456	2,001	873	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.316297	12,575	16,552	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188817	3,788	715	54.00
60.00	06000	LABORATORY	0.152075	19,548	2,973	60.00
65.00	06500	RESPIRATORY THERAPY	0.449199	3,723	1,672	65.00
66.00	06600	PHYSICAL THERAPY	0.476867	21	10	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.598935	18	11	67.00
68.00	06800	SPEECH PATHOLOGY	0.526204	191	101	68.00
69.00	06900	ELECTROCARDIOLOGY	0.242527	643	156	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.264311	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.889973	453	403	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.350821	12,642	4,435	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.601200	0	0	88.00
90.00	09000	CLINIC	0.596097	0	0	90.00
90.01	09001	WOUND CLINC	0.322616	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	1.831480	0	0	90.02
91.00	09100	EMERGENCY	0.373879	2,193	820	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.647914	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		57,796	28,721	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)		57,796		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3

Component CCN: 15-Z329 | Date/Time Prepared: 5/31/2022 10:24 am

Title XIX | Swing Beds - SNF | 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.436456	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.316297	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188817	0	0	54.00
60.00	06000	LABORATORY	0.152075	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.449199	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.476867	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.598935	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.526204	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.242527	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.264311	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.889973	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.350821	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.601200	0	0	88.00
90.00	09000	CLINIC	0.596097	0	0	90.00
90.01	09001	WOUND CLINC	0.322616	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	1.831480	0	0	90.02
91.00	09100	EMERGENCY	0.373879	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.647914	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1329	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/31/2022 10:24 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	16,521,787	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	16,521,787	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	16,687,005	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	142,466	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	10,612,379	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	5,932,160	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	5,932,160	30.00
31.00	Primary payer payments	1,548	31.00
32.00	Subtotal (line 30 minus line 31)	5,930,612	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)	636,680	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	413,842	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	636,680	36.00
37.00	Subtotal (see instructions)	6,344,454	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	6,344,454	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	9,185,123	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-2,840,669	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2022 10:24 am

Title XVIII | Hospital | Cost

		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		5,938,757		9,185,123	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)		5,938,757		9,185,123	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		876,664		2,840,669	6.02
7.00	Total Medicare program liability (see instructions)		5,062,093		6,344,454	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1329 | Component CCN: 15-Z329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2022 10:24 am

Title XVIII | Swing Beds - SNF | Cost

		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		74,315		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	225,200		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)		225,200		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)		299,515		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		4,867		0	6.02
7.00	Total Medicare program liability (see instructions)		294,648		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: 15-1329	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/31/2022 10:24 am
	Title XVIII	Hospital	Cost

			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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1329 | Component CCN: 15-Z329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-2 | Date/Time Prepared: 5/31/2022 10:24 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	196,457	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	98,377	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	149	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	294,834	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	294,834	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	294,834	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	186	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	294,648	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	294,648	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	299,515	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	-4,867	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1329 Component CCN: 15-Z329	Period: From 01/01/2021 To 12/31/2021	Worksheet E-2 Date/Time Prepared: 5/31/2022 10:24 am
	Title XIX	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0		3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0		19.25
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0		21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	0		22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1329	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prepared: 5/31/2022 10:24 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,568,674	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	5,568,674	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,624,361	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	5,624,361	19.00
20.00	Deductibles (exclude professional component)	546,765	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,077,596	22.00
23.00	Coinsurance	33,238	23.00
24.00	Subtotal (line 22 minus line 23)	5,044,358	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	27,284	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	17,735	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,284	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,062,093	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	5,062,093	30.00
30.01	Sequestration adjustment (see instructions)	0	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	5,938,757	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-876,664	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1329	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2022 10:24 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	47,571		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	47,571	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	47,571	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	53,095		8.00
9.00	Ancillary service charges	57,796	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	110,891	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	110,891	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	63,320	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	47,571	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	47,571	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	47,571	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	47,571	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	47,571	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	47,571	0	40.00
41.00	Interim payments	99,326	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-51,755	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/31/2022 10:24 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	6,802,841	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	46,970,559	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-28,390,616	0	0	0	6.00
7.00	Inventory	1,305,709	0	0	0	7.00
8.00	Prepaid expenses	2,281,592	0	0	0	8.00
9.00	Other current assets	884,829	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)	29,854,914	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	5,798,684	0	0	0	12.00
13.00	Land improvements	278,583	0	0	0	13.00
14.00	Accumulated depreciation	-240,194	0	0	0	14.00
15.00	Buildings	81,184,011	0	0	0	15.00
16.00	Accumulated depreciation	-51,723,186	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	5,263,075	0	0	0	19.00
20.00	Accumulated depreciation	-5,196,182	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	65,509,707	0	0	0	23.00
24.00	Accumulated depreciation	-48,526,616	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)	52,347,882	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	118,415,383	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	118,415,383	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	200,618,179	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	8,060,348	0	0	0	37.00
38.00	Salaries, wages, and fees payable	358,615	0	0	0	38.00
39.00	Payroll taxes payable	8,213,788	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,162,765	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19,795,516	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	32,262,521	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	32,262,521	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	52,058,037	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	148,560,142				52.00
53.00	Specific purpose fund		0			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)	148,560,142	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	200,618,179	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 | Date/Time Prepared: 5/31/2022 10:24 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		130,801,625		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		21,671,904				2.00
3.00	Total (sum of line 1 and line 2)		152,473,529		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	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)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		152,473,529		0		11.00
12.00	FQHC	3,913,387		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)		3,913,387		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		148,560,142		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			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)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	FQHC		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: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/31/2022 10:24 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,255,950		7,255,950	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,255,950		7,255,950	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,335,132		1,335,132	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)	1,335,132		1,335,132	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,591,082		8,591,082	17.00
18.00	Ancillary services	26,286,450	169,214,107	195,500,557	18.00
19.00	Outpatient services	1,129,173	39,671,163	40,800,336	19.00
20.00	RURAL HEALTH CLINIC	0	1,596,586	1,596,586	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	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	0	1,826,705	1,826,705	26.00
27.00	OTHER PRO FEES	2,807,688	21,015,039	23,822,727	27.00
27.01	PRO FEES	312,003	15,686,795	15,998,798	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	39,126,396	249,010,395	288,136,791	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		115,841,565		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)		115,841,565		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-3 | Date/Time Prepared: 5/31/2022 10:24 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	288,136,791	1.00
2.00	Less contractual allowances and discounts on patients' accounts	168,965,195	2.00
3.00	Net patient revenues (line 1 minus line 2)	119,171,596	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	115,841,565	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,330,031	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	2,744,433	24.00
24.01	CONTRIBUTIONS	57,813	24.01
24.02	INVESTMENT RETURN	27,000	24.02
24.03	UNREALIZED GAIN, DERIVATIVE	12,874,169	24.03
24.04	UNREALIZED GAIN, INVESTMENTS	545,215	24.04
24.05	TEMPORARILY RESTRICTED ASSETS	0	24.05
24.06	TEMPORARILY RESTRICTED ASSETS	18,079	24.06
24.50	COVID-19 PHE Funding	2,075,164	24.50
25.00	Total other income (sum of lines 6-24)	18,341,873	25.00
26.00	Total (line 5 plus line 25)	21,671,904	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	21,671,904	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2021 To 12/31/2021 | Worksheet O | Date/Time Prepared: 5/31/2022 10:24 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	197,569	150,146	347,715	0	347,715	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	49,006	49,006	0	49,006	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	79,725	79,725	0	79,725	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	13,993	13,993	0	13,993	26.00
27.00	NURSE PRACTITIONER**	1,924	0	1,924	0	1,924	27.00
28.00	REGISTERED NURSE**	365,850	0	365,850	0	365,850	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	70,130	0	70,130	0	70,130	33.00
34.00	SPIRITUAL COUNSELING**	18,803	0	18,803	0	18,803	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	31,360	0	31,360	0	31,360	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	685,636	292,870	978,506	0	978,506	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2021 To 12/31/2021 | Worksheet O | Date/Time Prepared: 5/31/2022 10:24 am

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	347,715		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	49,006		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	79,725		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	13,993		26.00
27.00	NURSE PRACTITIONER**	0	1,924		27.00
28.00	REGISTERED NURSE**	0	365,850		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	70,130		33.00
34.00	SPIRITUAL COUNSELING**	0	18,803		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	31,360		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	0	978,506		100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 15-1329 Hospice CCN: 15-1551 | Period: From 01/01/2021 To 12/31/2021 | Worksheet O-2 | Date/Time Prepared: 5/31/2022 10:24 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	13,993	13,993	0	13,993	26.00
27.00	NURSE PRACTITIONER	1,923	0	1,923	0	1,923	27.00
28.00	REGISTERED NURSE	365,678	0	365,678	0	365,678	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	70,097	0	70,097	0	70,097	33.00
34.00	SPIRITUAL COUNSELING	18,794	0	18,794	0	18,794	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	31,345	0	31,345	0	31,345	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	487,837	13,993	501,830	0	501,830	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	13,993		26.00
27.00	NURSE PRACTITIONER	0	1,923		27.00
28.00	REGISTERED NURSE	0	365,678		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	70,097		33.00
34.00	SPIRITUAL COUNSELING	0	18,794		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	31,345		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	501,830		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Provider CCN: 15-1329 Hospice CCN: 15-1551 | Period: From 01/01/2021 To 12/31/2021 | Worksheet O-3 Date/Time Prepared: 5/31/2022 10:24 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	1	0	1	0	1	27.00
28.00	REGISTERED NURSE	172	0	172	0	172	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	33	0	33	0	33	33.00
34.00	SPIRITUAL COUNSELING	9	0	9	0	9	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	15	0	15	0	15	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	230	0	230	0	230	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	1		27.00
28.00	REGISTERED NURSE	0	172		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	33		33.00
34.00	SPIRITUAL COUNSELING	0	9		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	15		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	230		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 15-1329 Hospice CCN: 15-1551

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

Worksheet O-5

Date/Time Prepared: 5/31/2022 10:24 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	46,741	46,741	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	93,633	93,633	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	213,247	213,247	3.00
4.00	ADMINISTRATIVE & GENERAL	347,715	291,679	639,394	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	121,300	121,300	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	67,877	67,877	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	49,006		49,006	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	79,725	0	79,725	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	501,830		501,830	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	230		230	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0		0	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	978,506	834,477	1,812,983	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2021 To 12/31/2021 | Worksheet O-6 Part I | Date/Time Prepared: 5/31/2022 10:24 am

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	46,741	46,741				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	93,633		93,633			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	213,247	0	0	213,247		3.00
4.00	ADMINISTRATIVE & GENERAL	639,394	46,741	93,633	0	779,768	4.00
5.00	PLANT OPERATION & MAINTENANCE	121,300	0	0	0	121,300	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	67,877	0	0	0	67,877	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	49,006	0	0	0	49,006	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	79,725	0	0	0	79,725	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	501,830			213,146	714,976	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	230	0	0	101	331	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	1,812,983	46,741	93,633	213,247	1,812,983	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 Hospice CCN: 15-1551 | Period: From 01/01/2021 To 12/31/2021 | Worksheet O-6 Part I Date/Time Prepared: 5/31/2022 10:24 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	779,768					4.00
5.00	PLANT OPERATION & MAINTENANCE	91,545	212,845				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	51,227	0		119,104		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	36,985	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	60,169	212,845		119,104		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	539,592					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	250	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	779,768	212,845	0	119,104	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 Hospice CCN: 15-1551 | Period: From 01/01/2021 To 12/31/2021 | Worksheet O-6 Part I Date/Time Prepared: 5/31/2022 10:24 am

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			85,991		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0	85,951	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	40	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	0	85,991	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 Hospice CCN: 15-1551 | Period: From 01/01/2021 To 12/31/2021 | Worksheet O-6 Part I Date/Time Prepared: 5/31/2022 10:24 am

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	471,843					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	471,620	0	0		1,812,139	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	223	0	0	0	844	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	471,843	0	0	0	1,812,983	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

Worksheet O-6
Part II
Date/Time Prepared:
5/31/2022 10:24 am

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	46,741					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		93,633				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	213,247			3.00
4.00	ADMINISTRATIVE & GENERAL	46,741	93,633	0	-779,768	1,033,215	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	121,300	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	67,877	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	49,006	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	79,725	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			213,146	0	714,976	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	101	0	331	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	46,741	93,633	213,247		779,768	100.00
101.00	UNIT COST MULTIPLIER	1.000000	1.000000	1.000000		0.754701	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

Worksheet O-6
Part II
Date/Time Prepared:
5/31/2022 10:24 am

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	216,433					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		121,113			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	216,433		121,113		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	212,845	0	119,104	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.983422	0.000000	0.983412	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

Worksheet O-6
Part II
Date/Time Prepared:
5/31/2022 10:24 am

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	0					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			87,331			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	142,063	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	87,290	0	141,996	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	41	0	67	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	85,991	0	471,843	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.984656	0.000000	3.321364	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

Worksheet O-6 Part II
Date/Time Prepared: 5/31/2022 10:24 am

Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 15-1329 Hospice CCN: 15-1551

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

Worksheet O-7

Date/Time Prepared: 5/31/2022 10:24 am

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.476867	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.598935	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.526204	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.350821	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.152075	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.264311	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2021 To 12/31/2021 | Worksheet O-8 | Date/Time Prepared: 5/31/2022 10:24 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			1,812,139	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			8,480	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			213.70	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	8,000	93		9.00
10.00	Program cost (line 8 times line 9)	1,709,600	19,874		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			844	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			8	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			105.50	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	4	0		14.00
15.00	Program cost (line 13 times line 14)	422	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			0	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			0	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			0.00	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	0	0		19.00
20.00	Program cost (line 18 times line 19)	0	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,812,983	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			8,488	22.00
23.00	Average cost per diem (line 21 divided by line 22)			213.59	23.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/31/2022 10:24 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	159,204	6,003	165,207	0	165,207	1.00
2.00	Physician Assistant	61,535	0	61,535	0	61,535	2.00
3.00	Nurse Practitioner	413,407	0	413,407	0	413,407	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	153,238	0	153,238	0	153,238	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	355,792	0	355,792	0	355,792	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,143,176	6,003	1,149,179	0	1,149,179	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	61,296	61,296	0	61,296	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	61,296	61,296	0	61,296	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,143,176	67,299	1,210,475	0	1,210,475	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	53,681	53,681	0	53,681	29.00
30.00	Administrative Costs	271,589	17,838	289,427	0	289,427	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	271,589	71,519	343,108	0	343,108	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,414,765	138,818	1,553,583	0	1,553,583	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/31/2022 10:24 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	165,207		1.00
2.00	Physician Assistant	0	61,535		2.00
3.00	Nurse Practitioner	0	413,407		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	153,238		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	355,792		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,149,179		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	61,296		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	61,296		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,210,475		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	53,681		29.00
30.00	Administrative Costs	0	289,427		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	343,108		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,553,583		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-2 | Date/Time Prepared: 5/31/2022 10:24 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.66	1,876	1	1		1.00
2.00	Physician Assistant	0.37	931	1	0		2.00
3.00	Nurse Practitioner	2.66	7,645	1	3		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.69	10,452		4	10,452	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.69	10,452			10,452	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,210,475	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,210,475	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					343,108	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,002,870	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,345,978	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,345,978	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,345,978	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,556,453	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1329 Component CCN: 15-8511	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/31/2022 10:24 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,556,453	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			20,459	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,535,994	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			10,452	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			10,452	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			242.63	7.00
		Calculation of Limit (1)			
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	250.53		8.00
9.00	Rate for Program covered visits (see instructions)	242.63	242.63		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	268	1,112		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	65,025	269,805		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	334,830		16.00
16.01	Total program charges (see instructions)(from contractor's records)		202,417		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		18,197		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		30,101		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		219,706		16.04
16.05	Total program cost (see instructions)	0	249,807		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		30,096		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		30,828		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		249,807		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		8,828		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		258,635		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		258,635		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		247,367		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		11,268		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/31/2022 10:24 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,149,179	1,149,179	1,149,179	1,149,179	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000260	0.001346	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	299	1,547	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	4,152	3,689	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4,451	5,236	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,210,475	1,210,475	1,210,475	1,210,475	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,345,978	1,345,978	1,345,978	1,345,978	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.003677	0.004326	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	4,949	5,823	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	9,400	11,059	0	0	10.00
11.00	Total number of injections/infusions (from your records)	42	217	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	223.81	50.96	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	21	81	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	4,700	4,128	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		20,459			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		8,828			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-5 | Date/Time Prepared: 5/31/2022 10:24 am

RHC I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		222,067	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	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		12/01/2021	25,300	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		25,300	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		247,367	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		11,268	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		258,635	7.00

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