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: 15-0030	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/26/2022 3:43 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/26/2022 Time: 3:43 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION 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 HENRY COUNTY MEMORIAL HOSPITAL (15-0030) 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	Darin Brown		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	Darin Brown			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	8,197	-76,049	0	-100,876	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		183,405		0	10.00
10.01	RURAL HEALTH CLINIC II	0		325,874		0	10.01
10.02	RURAL HEALTH CLINIC III	0		33,428		0	10.02
200.00	Total	0	8,197	466,658	0	-100,876	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 3:43 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 NORTH 16TH STREET	PO Box:			1.00
2.00	City: NEW CASTLE	State: IN	Zip Code: 47392-	County: HENRY	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	HENRY COUNTY MEMORIAL HOSPITAL	150030	99915	1	07/01/1996	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HCMH HOME CARE	157430	99915		06/14/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HOSP-BASED HOSPICE	151564	99915		08/31/1998				14.00
15.00	Hospital-Based Health Clinic - RHC	NEW CASTLE FAMILY AND INTERNAL MED	158520	99915		04/11/2017	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	NCFIM - NORHTFIELD PARK	158525	99915		12/04/2017	N	O	O	15.01
15.02	Hospital-Based Health Clinic - RHC III	CAMBRIDGE CITY FAMILY HEALTH PARTNER	158556	99915		06/02/2020	N	O	O	15.02
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)	9		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 3:43 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	268	1,273	0	0	160	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1		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.	01/01/2021	12/31/2021	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)	Y	Y	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.				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: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 3:43 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 3:43 pm

				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: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 3:43 pm

		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?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 3:43 pm

				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.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	207,594	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.		N			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: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 3:43 pm

		1.00	2.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		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.	Y	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0030	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 3:43 pm

		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: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2022 3:43 pm

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

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

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for 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	03/14/2022	Y	03/14/2022	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: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2022 3:43 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	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.	Y	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.	N	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

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		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: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2022 3:43 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	38	13,870	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		38	13,870	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,650	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		48	17,520	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	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
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		48				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: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 3:43 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,833	267	7,219			1.00
2.00	HMO and other (see instructions)	2,059	1,432				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,833	267	7,219			7.00
8.00	INTENSIVE CARE UNIT	661	0	2,030			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	435			13.00
14.00	Total (see instructions)	3,494	267	9,684	0.00	457.63	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	3,962	598	9,695	0.00	12.88	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	5.71	24.00
24.10	HOSPICE (non-distinct part)			44			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	5,976	3,784	21,735	0.00	56.10	26.00
26.01	RURAL HEALTH CLINIC II	6,976	16,362	48,721	0.00	91.09	26.01
26.02	RURAL HEALTH CLINIC III	896	904	4,664	0.00	6.20	26.02
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	629.61	27.00
28.00	Observation Bed Days		243	1,404			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	2	50			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: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 3:43 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	881	45	2,437	1.00
2.00	HMO and other (see instructions)			430	390		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	881	45	2,437	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
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part II | Date/Time Prepared: 5/26/2022 3:43 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	56,157,285	-6,640	56,150,645	1,309,579.00	42.88	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		15,000	0	15,000	180.00	83.33	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		10,542,872	0	10,542,872	72,015.00	146.40	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		8,816,941	0	8,816,941	293,715.00	30.02	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,418,159	297,316	3,715,475	100,019.00	37.15	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,234,566	0	1,234,566	23,286.00	53.02	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		171,000	0	171,000	1,373.00	124.54	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		10,360,808	0	10,360,808			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		1,203,328	0	1,203,328			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		3,002	0	3,002			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		1,449,311	0	1,449,311			23.00
24.00	Wage-related costs (RHC/FQHC)		3,278,179	0	3,278,179			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part II | Date/Time Prepared: 5/26/2022 3:43 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	1,604,905	-1,294,173	310,732	8,990.00	34.56	26.00
27.00	Administrative & General	5.00	6,601,487	149,832	6,751,319	145,400.00	46.43	27.00
28.00	Administrative & General under contract (see inst.)		279,859	0	279,859	1,013.00	276.27	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,457,285	34,576	1,491,861	49,767.00	29.98	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		921,605	0	921,605	61,440.00	15.00	33.00
34.00	Dietary	10.00	878,075	-528,892	349,183	15,637.00	22.33	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	292,633	292,633	13,102.00	22.33	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,506,693	85,068	2,591,761	47,963.00	54.04	38.00
39.00	Central Services and Supply	14.00	570,388	13,533	583,921	14,935.00	39.10	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	704,536	16,716	721,252	28,604.00	25.22	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part III Date/Time Prepared: 5/26/2022 3:43 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		37,998,936	-6,640	37,992,296	1,006,302.00	37.75	1.00
2.00	Excluded area salaries (see instructions)		3,418,159	297,316	3,715,475	100,019.00	37.15	2.00
3.00	Subtotal salaries (line 1 minus line 2)		34,580,777	-303,956	34,276,821	906,283.00	37.82	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,405,566	0	1,405,566	24,659.00	57.00	4.00
5.00	Subtotal wage-related costs (see inst.)		10,363,810	0	10,363,810	0.00	30.24	5.00
6.00	Total (sum of lines 3 thru 5)		46,350,153	-303,956	46,046,197	930,942.00	49.46	6.00
7.00	Total overhead cost (see instructions)		15,524,833	-1,230,707	14,294,126	386,851.00	36.95	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part IV | Date/Time Prepared: 5/26/2022 3:43 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,187,798	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	9,715,691	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	126,929	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	223,795	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	795,612	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	346,011	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	3,619,609	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	13,340	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	32,462	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	17,061,247	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part V | Date/Time Prepared: 5/26/2022 3:43 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,234,566	17,061,247	1.00
2.00	Hospital	1,234,566	17,061,247	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-0030 | Component CCN: 15-7430 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-4 | Date/Time Prepared: 5/26/2022 3:43 pm

Home Health Agency I | PPS

		1.00	
0.00	County		0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	200.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent) Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		3.14	0.00	3.14	4.00
5.00	Other Administrative Personnel		0.77	0.00	0.77	5.00
6.00	Direct Nursing Service		8.51	0.00	8.51	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		3.89	0.00	3.89	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.27	0.00	0.27	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.13	0.00	0.13	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.88	0.00	0.88	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00

		CBSA Data
		1.00
	HOME HEALTH AGENCY CBSA CODES	
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.	3
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	17140
20.01		34620
20.02		99915

		Full Episodes Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,116	165	11	0	1,292	21.00
22.00	Skilled Nursing Visit Charges	396,480	58,672	3,916	0	459,068	22.00
23.00	Physical Therapy Visits	1,452	208	5	0	1,665	23.00
24.00	Physical Therapy Visit Charges	516,147	73,929	1,780	0	591,856	24.00
25.00	Occupational Therapy Visits	163	71	0	0	234	25.00
26.00	Occupational Therapy Visit Charges	57,050	24,782	0	0	81,832	26.00
27.00	Speech Pathology Visits	87	56	0	0	143	27.00
28.00	Speech Pathology Visit Charges	30,972	19,936	0	0	50,908	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	486	142	0	0	628	31.00
32.00	Home Health Aide Visit Charges	81,074	23,698	0	0	104,772	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,304	642	16	0	3,962	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,081,723	201,017	5,696	0	1,288,436	35.00
36.00	Total Number of Episodes (standard/non outlier)	281		10	0	291	36.00
37.00	Total Number of Outlier Episodes		28		0	28	37.00
38.00	Total Non-Routine Medical Supply Charges	1,123	662	0	0	1,785	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0030 | Component CCN: 15-8520 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/26/2022 3:43 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	2200 FOREST RIDGE PARKWAY	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	NEW CASTLE	IN	47362	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	17:00	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		HENRY				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	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0030 | Component CCN: 15-8520 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/26/2022 3:43 pm

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	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0030 | Component CCN: 15-8525 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/26/2022 3:43 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			152 WITTENBRAKER AVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NEW CASTLE		IN	47362	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			07:30	19:00	07:30	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		HENRY				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	19:00	07:30	19:00	07:30	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0030 Component CCN: 15-8525	Period: From 01/01/2021 To 12/31/2021	Worksheet S-8 Date/Time Prepared: 5/26/2022 3:43 pm
		RHC II	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0030 | Component CCN: 15-8556 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/26/2022 3:43 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			415 E. MAIN ST.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CAMBRIDGE CITY		IN	47327	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	19:00	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		HENRY				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	19:00	08:00	19:00	08:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0030
Component CCN: 15-8556

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

Worksheet S-8
Date/Time Prepared:
5/26/2022 3:43 pm

RHC III | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	19:00	08:00	12:00		11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/26/2022 3:43 pm

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	2,543	125	468	3,136	11.00
12.00	Hospice Inpatient Respite Care	5	0	5	10	12.00
13.00	Hospice General Inpatient Care	14	3	11	28	13.00
14.00	Total Hospice Days	2,562	128	484	3,174	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: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-10 | Date/Time Prepared: 5/26/2022 3:43 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.306255	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,553,926	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	51,204,412	6.00
7.00	Medicaid cost (line 1 times line 6)	15,681,607	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)	12,127,681	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)	12,127,681	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)	2,445,321	476,554	2,921,875	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	748,892	476,554	1,225,446	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)	748,892	476,554	1,225,446	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)	5,520,993	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	149,727	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	230,348	27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,290,645	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,700,907	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,926,353	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	15,054,034	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/26/2022 3:43 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		5,392,553	5,392,553	-88,894	5,303,659	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	360,404	360,404	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,604,905	10,803,040	12,407,945	2,324,942	14,732,887	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,601,487	13,260,181	19,861,668	146,006	20,007,674	5.00
7.00	00700	OPERATION OF PLANT	1,457,285	1,860,736	3,318,021	34,576	3,352,597	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	464,136	464,136	0	464,136	8.00
9.00	00900	HOUSEKEEPING	0	982,548	982,548	0	982,548	9.00
10.00	01000	DIETARY	878,075	540,086	1,418,161	-859,180	558,981	10.00
11.00	01100	CAFETERIA	0	0	0	468,454	468,454	11.00
13.00	01300	NURSING ADMINISTRATION	2,506,693	365,159	2,871,852	77,120	2,948,972	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	570,388	492,454	1,062,842	13,533	1,076,375	14.00
15.00	01500	PHARMACY	0	5,732,059	5,732,059	-206,772	5,525,287	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	704,536	177,085	881,621	16,596	898,217	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,696,335	3,081,817	9,778,152	-784,962	8,993,190	30.00
31.00	03100	INTENSIVE CARE UNIT	1,842,178	839,285	2,681,463	43,708	2,725,171	31.00
43.00	04300	NURSERY	0	0	0	686,829	686,829	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,682,821	12,334,748	18,017,569	-10,420,668	7,596,901	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	216,311	216,311	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,046,717	1,032,392	3,079,109	-273,601	2,805,508	54.00
57.00	05700	CT SCAN	208,880	1,059,696	1,268,576	4,956	1,273,532	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	149,708	485,296	635,004	3,552	638,556	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,160,567	3,669,256	5,829,823	51,262	5,881,085	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	880,808	521,832	1,402,640	19,427	1,422,067	65.00
66.00	06600	PHYSICAL THERAPY	1,338,157	904,692	2,242,849	31,578	2,274,427	66.00
67.00	06700	OCCUPATIONAL THERAPY	227,396	17,040	244,436	5,395	249,831	67.00
68.00	06800	SPEECH PATHOLOGY	85,396	6,095	91,491	2,026	93,517	68.00
69.00	06900	ELECTROCARDIOLOGY	204,992	203,717	408,709	4,864	413,573	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-407,547	-407,547	1,808,646	1,401,099	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	8,351,239	8,351,239	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	168,396	20,461	188,857	3,995	192,852	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,753,808	2,359,485	7,113,293	-1,189,497	5,923,796	88.00
88.01	08801	RURAL HEALTH CLINIC II	8,261,189	4,411,648	12,672,837	-1,266,271	11,406,566	88.01
88.02	08802	RURAL HEALTH CLINIC III	791,652	508,209	1,299,861	-100,388	1,199,473	88.02
91.00	09100	EMERGENCY	2,916,757	2,212,566	5,129,323	69,204	5,198,527	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,145,801	348,851	1,494,652	14,445	1,509,097	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	516,259	215,006	731,265	6,527	737,792	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,401,186	73,894,582	128,295,768	-424,638	127,871,130	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,587,868	606,614	2,194,482	-77,939	2,116,543	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	0	88,894	88,894	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	206,593	206,593	0	206,593	194.05
194.06	07956	DR AFZAL	0	7,203	7,203	0	7,203	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	0	0	411,560	411,560	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	0	469	469	0	469	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	65,512	65,512	0	65,512	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	168,231	1,714,014	1,882,245	2,123	1,884,368	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
200.00		TOTAL (SUM OF LINES 118 through 199)	56,157,285	76,494,987	132,652,272	0	132,652,272	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/26/2022 3:43 pm

		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	-119,829	5,183,830		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	360,404		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,929,332	17,662,219		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,669,055	15,338,619		5.00
7.00	00700	OPERATION OF PLANT	0	3,352,597		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	464,136		8.00
9.00	00900	HOUSEKEEPING	600	983,148		9.00
10.00	01000	DIETARY	-28,434	530,547		10.00
11.00	01100	CAFETERIA	-259,708	208,746		11.00
13.00	01300	NURSING ADMINISTRATION	89,382	3,038,354		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,076,375		14.00
15.00	01500	PHARMACY	-795,344	4,729,943		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-26,580	871,637		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,307,523	6,685,667		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,725,171		31.00
43.00	04300	NURSERY	0	686,829		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-3,324,261	4,272,640		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	216,311		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,286	2,804,222		54.00
57.00	05700	CT SCAN	-720,249	553,283		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-285,167	353,389		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-30,740	5,850,345		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	24,020	1,446,087		65.00
66.00	06600	PHYSICAL THERAPY	-660,794	1,613,633		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	249,831		67.00
68.00	06800	SPEECH PATHOLOGY	0	93,517		68.00
69.00	06900	ELECTROCARDIOLOGY	0	413,573		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,401,099		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	8,351,239		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	CARDIAC REHAB	0	192,852		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-440,147	5,483,649		88.00
88.01	08801	RURAL HEALTH CLINIC II	-2,208,417	9,198,149		88.01
88.02	08802	RURAL HEALTH CLINIC III	-142,322	1,057,151		88.02
91.00	09100	EMERGENCY	-34,822	5,163,705		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-15,343	1,493,754		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0		114.00
116.00	11600	HOSPICE	-15,693	722,099		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,042,380	114,828,750		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-46,133	2,070,410		192.00
194.00	07950	HOSPITALIST	0	0		194.00
194.01	07951	RENTAL	0	88,894		194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	206,593		194.05
194.06	07956	DR AFZAL	0	7,203		194.06
194.07	07957	PHILLIPS HALL	0	0		194.07
194.08	07958	OB DRS	0	0		194.08
194.09	07959	THE WATERS	0	411,560		194.09
194.10	07960	CAMBRIDGE CITY	0	0		194.10
194.11	07961	WELL BEING	0	469		194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	65,512		194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0		194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	1,884,368		194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0		194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0		194.16
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,088,513	119,563,759		200.00

RECLASSIFICATIONS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 3:43 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - OB/NURSERY/L&D				
1.00	NURSERY	43.00	594,583	78,139	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	187,259	24,609	2.00
	0		781,842	102,748	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	285,851	175,821	1.00
	0		285,851	175,821	
	C - WATERS EXCLUSIONS				
1.00	THE WATERS	194.09	251,134	154,467	1.00
	0		251,134	154,467	
	D - DEPRECIATION POB				
1.00	RENTAL	194.01	0	88,894	1.00
	0		0	88,894	
	E - EQUIPMENT RENTAL				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	360,404	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
	0		0	360,404	
	F - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	8,351,239	1.00
	0		0	8,351,239	
	G - BONUS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	7,356	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	156,472	0	2.00
3.00	OPERATION OF PLANT	7.00	34,576	0	3.00
4.00	DIETARY	10.00	8,093	0	4.00
5.00	CAFETERIA	11.00	6,782	0	5.00
6.00	NURSING ADMINISTRATION	13.00	60,068	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	13,533	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	16,716	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	140,330	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	43,708	0	10.00
11.00	NURSERY	43.00	14,107	0	11.00
12.00	OPERATING ROOM	50.00	134,833	0	12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	4,443	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	48,561	0	14.00
15.00	CT SCAN	57.00	4,956	0	15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	3,552	0	16.00
17.00	LABORATORY	60.00	51,262	0	17.00
18.00	RESPIRATORY THERAPY	65.00	20,898	0	18.00
19.00	PHYSICAL THERAPY	66.00	31,750	0	19.00
20.00	OCCUPATIONAL THERAPY	67.00	5,395	0	20.00
21.00	SPEECH PATHOLOGY	68.00	2,026	0	21.00
22.00	ELECTROCARDIOLOGY	69.00	4,864	0	22.00
23.00	CARDIAC REHAB	76.00	3,995	0	23.00
24.00	RURAL HEALTH CLINIC	88.00	107,712	0	24.00
25.00	RURAL HEALTH CLINIC II	88.01	201,441	0	25.00
26.00	RURAL HEALTH CLINIC III	88.02	18,783	0	26.00
27.00	EMERGENCY	91.00	69,204	0	27.00
28.00	HOME HEALTH AGENCY	101.00	27,186	0	28.00
29.00	HOSPICE	116.00	12,249	0	29.00
30.00	PHYSICIANS' PRIVATE OFFICES	192.00	36,727	0	30.00
31.00	THE WATERS	194.09	5,959	0	31.00
32.00	HENRY COUNTY RADIOLOGY	194.14	3,992	0	32.00
	TOTALS		1,301,529	0	
	I - MEDICAL DIRECTOR RECLASS				
1.00	NURSING ADMINISTRATION	13.00	25,000	0	1.00
	0		25,000	0	
	J - VERO RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,640	1.00
	TOTALS		0	6,640	
	L - MED SUPPLIES RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,159,885	1.00
	0		0	10,159,885	

RECLASSIFICATIONS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 3:43 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	M - FOREST RIDGE STAFF RECLASS					
1.00	RURAL HEALTH CLINIC	88.00	14,931	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	228,987	0		2.00
	0		243,918	0		
	O - BENEFIT RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,612,475		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
	0		0	3,612,475		
500.00	Grand Total: Increases		2,889,274	23,012,573		500.00

RECLASSIFICATIONS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 3:43 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - OB/NURSERY/L&D						
1.00	ADULTS & PEDIATRICS	30.00	781,842	102,748	0		1.00
2.00		0.00	0	0	0		2.00
	0		781,842	102,748			
	B - CAFETERIA						
1.00	DIETARY	10.00	285,851	175,821	0		1.00
	0		285,851	175,821			
	C - WATERS EXCLUSIONS						
1.00	DIETARY	10.00	251,134	154,467	0		1.00
	0		251,134	154,467			
	D - DEPRECIATION POB						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	88,894	9		1.00
	0		0	88,894			
	E - EQUIPMENT RENTAL						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,768	9		1.00
2.00	NURSING ADMINISTRATION	13.00	0	7,948	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	120	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	25,763	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	322,162	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	1,471	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	172	0		7.00
	0		0	360,404			
	F - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	8,351,239	0		1.00
	0		0	8,351,239			
	G - BONUS RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,301,529	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
	TOTALS		1,301,529	0			
	I - MEDICAL DIRECTOR RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	25,000	0	0		1.00
	0		25,000	0			
	J - VERO RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	6,640	0	0		1.00
	TOTALS		6,640	0			
	L - MED SUPPLIES RECLASS						
1.00	OPERATING ROOM	50.00	0	10,159,885	0		1.00
	0		0	10,159,885			
	M - FOREST RIDGE STAFF RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	228,987	0	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	14,931	0	0		2.00
	0		243,918	0			

RECLASSIFICATIONS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 3:43 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	O - BENEFIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,058	0		1.00
2.00	PHARMACY	15.00	0	206,772	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	14,939	0		3.00
4.00	OPERATING ROOM	50.00	0	395,616	0		4.00
5.00	RURAL HEALTH CLINIC	88.00	0	1,083,153	0		5.00
6.00	RURAL HEALTH CLINIC II	88.01	0	1,696,699	0		6.00
7.00	RURAL HEALTH CLINIC III	88.02	0	119,171	0		7.00
8.00	HOME HEALTH AGENCY	101.00	0	12,741	0		8.00
9.00	HOSPICE	116.00	0	5,722	0		9.00
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	74,735	0		10.00
11.00	HENRY COUNTY RADIOLOGY	194.14	0	1,869	0		11.00
	0		0	3,612,475			
500.00	Grand Total: Decreases		2,895,914	23,005,933			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2022 3:43 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	46,000	0	0	0	0	1.00
2.00	Land Improvements	2,112,571	0	0	0	597,769	2.00
3.00	Buildings and Fixtures	42,082,284	0	0	0	2,377,024	3.00
4.00	Building Improvements	1,898,222	0	0	0	0	4.00
5.00	Fixed Equipment	22,759,639	0	0	0	781,462	5.00
6.00	Movable Equipment	38,261,372	1,994,041	0	1,994,041	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	107,160,088	1,994,041	0	1,994,041	3,756,255	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	107,160,088	1,994,041	0	1,994,041	3,756,255	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	46,000	0	1.00
2.00	Land Improvements	1,514,802	0	2.00
3.00	Buildings and Fixtures	39,705,260	0	3.00
4.00	Building Improvements	1,898,222	0	4.00
5.00	Fixed Equipment	21,978,177	0	5.00
6.00	Movable Equipment	40,255,413	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	105,397,874	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	105,397,874	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II Date/Time Prepared: 5/26/2022 3:43 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	5,229,786	0	162,767	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,229,786	0	162,767	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	5,392,553	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	5,392,553	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III Date/Time Prepared: 5/26/2022 3:43 pm

	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	65,142,461	0	65,142,461	0.618062	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	40,255,413	0	40,255,413	0.381938	0	2.00
3.00	Total (sum of lines 1-2)	105,397,874	0	105,397,874	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	5,140,892	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	360,404	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,501,296	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	42,938	0	0	0	5,183,830	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	360,404	2.00
3.00	Total (sum of lines 1-2)	42,938	0	0	0	5,544,234	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/26/2022 3:43 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-119,829	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-10,398	ADMINISTRATIVE & GENERAL	5.00	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)	A	-28,147	ADMINISTRATIVE & GENERAL	5.00	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	-6,976,399			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	-2,725,222			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-259,708	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	B	-6,188	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	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	UTILIZATION REVIEW-SNF	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
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/26/2022 3:43 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER OP REV - HUMAN RESOURSEC - MIS	B	-152	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	OTHER OP REV - PHY REAPP FEES	B	-43,118	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER OP REV	B	600	HOUSEKEEPING	9.00	0	33.02
33.03	DIETARY-OTHER OP REV	B	-28,434	DIETARY	10.00	0	33.03
33.04	OTHER OP REV - PHARMACY	B	-804,500	PHARMACY	15.00	0	33.04
33.05	OTHER OP REV - LABORATORY-LAB DRUG S	B	-2,254	LABORATORY	60.00	0	33.05
33.06	OTHER OP REV - AQUATICS - HLTH PROG	B	-88,222	PHYSICAL THERAPY	66.00	0	33.06
33.07	OTHER OP REV - NORTHFIELD PARK	B	-151,886	RURAL HEALTH CLINIC II	88.01	0	33.07
33.08	PUBLIC RELATIONS	A	-5,126	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	PUBLIC RELATIONS	A	-167,144	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	PUBLIC RELATIONS	A	-618	NURSING ADMINISTRATION	13.00	0	33.10
33.11	PUBLIC RELATIONS	A	-1,286	RADIOLOGY-DIAGNOSTIC	54.00	0	33.11
33.12	PUBLIC RELATIONS	A	-59,653	RURAL HEALTH CLINIC	88.00	0	33.12
33.13	PUBLIC RELATIONS	A	-37,192	RURAL HEALTH CLINIC II	88.01	0	33.13
33.14	PUBLIC RELATIONS	A	-56,022	RURAL HEALTH CLINIC III	88.02	0	33.14
33.15	PUBLIC RELATIONS	A	-1,764	EMERGENCY	91.00	0	33.15
33.16	PUBLIC RELATIONS	A	-300	HOME HEALTH AGENCY	101.00	0	33.16
33.17	PUBLIC RELATIONS	A	-648	HOSPICE	116.00	0	33.17
33.18	AHA & IHA DUES	A	-8,967	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	BENEFIT EXPENSE	A	2,934,610	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.19
33.20	NC FAMILY INTERNAL MEDICINE-OTHER OP	B	-97,800	RURAL HEALTH CLINIC	88.00	0	33.20
33.21	MEDICAL DIRECTOR	A	90,000	NURSING ADMINISTRATION	13.00	0	33.21
33.22	HAF EXPENSE	A	-4,369,044	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	PHYSICIAN RECRUITMENT	A	-27,235	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	PHYSICIAN RECRUITMENT	A	-36,467	OPERATING ROOM	50.00	0	33.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,088,513				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2022 3:43 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	RENT EXPENSE	0	15,002	1.00
2.00	15.00	PHARMACY	RENT EXPENSE	9,156	0	2.00
3.00	16.00	MEDICAL RECORDS & LIBRARY	RENT EXPENSE	10,872	31,264	3.00
3.01	57.00	CT SCAN	RENT EXPENSE	218,066	938,315	3.01
3.02	58.00	MAGNETIC RESONANCE IMAGING (	RENT EXPENSE	164,833	450,000	3.02
4.00	60.00	LABORATORY	RENT EXPENSE	6,201	34,687	4.00
4.01	65.00	RESPIRATORY THERAPY	RENT EXPENSE	24,020	0	4.01
4.02	66.00	PHYSICAL THERAPY	RENT EXPENSE	178,725	751,297	4.02
4.03	88.00	RURAL HEALTH CLINIC	RENT EXPENSE	239,831	522,525	4.03
4.04	88.01	RURAL HEALTH CLINIC II	RENT EXPENSE	619,424	1,290,739	4.04
4.05	88.02	RURAL HEALTH CLINIC III	RENT EXPENSE	66,293	152,593	4.05
4.06	101.00	HOME HEALTH AGENCY	RENT EXPENSE	7,438	22,481	4.06
4.07	116.00	HOSPICE	RENT EXPENSE	7,435	22,480	4.07
4.08	192.00	PHYSICIANS' PRIVATE OFFICES	RENT EXPENSE	2,617	48,750	4.08
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,554,911	4,280,133	5.00

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

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

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

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

6.00	G	HENRY COUNTY HO	100.00	HOSPITAL FOUNDA	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	MISC				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0030	Period: From 01/01/2021 To 12/31/2021	Worksheet A-8-1 Date/Time Prepared: 5/26/2022 3:43 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-15,002	0		1.00
2.00	9,156	0		2.00
3.00	-20,392	0		3.00
3.01	-720,249	0		3.01
3.02	-285,167	0		3.02
4.00	-28,486	0		4.00
4.01	24,020	0		4.01
4.02	-572,572	0		4.02
4.03	-282,694	0		4.03
4.04	-671,315	0		4.04
4.05	-86,300	0		4.05
4.06	-15,043	0		4.06
4.07	-15,045	0		4.07
4.08	-46,133	0		4.08
5.00	-2,725,222			5.00

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

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

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

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

6.00	MISC		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2022 3:43 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	13.00	NURSING ADMINISTRATION	25,000	0	25,000	211,500	260	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,307,523	2,307,523	0	211,500	0	2.00
3.00	50.00	OPERATING ROOM	3,306,701	3,287,794	18,907	246,400	180	3.00
4.00	60.00	LABORATORY	56,000	0	56,000	211,500	553	4.00
5.00	88.01	RURAL HEALTH CLINIC II	1,348,024	1,348,024	0	211,500	0	5.00
6.00	91.00	EMERGENCY	90,000	0	90,000	211,500	560	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			7,133,248	6,943,341	189,907		1,553	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	26,438	1,322	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	21,323	1,066	0	0	0	3.00
4.00	60.00	LABORATORY	56,230	2,812	0	0	0	4.00
5.00	88.01	RURAL HEALTH CLINIC II	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	56,942	2,847	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			160,933	8,047	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	26,438	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,307,523		2.00
3.00	50.00	OPERATING ROOM	0	21,323	0	3,287,794		3.00
4.00	60.00	LABORATORY	0	56,230	0	0		4.00
5.00	88.01	RURAL HEALTH CLINIC II	0	0	0	1,348,024		5.00
6.00	91.00	EMERGENCY	0	56,942	33,058	33,058		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	160,933	33,058	6,976,399		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/26/2022 3:43 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	5,183,830	5,183,830				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	360,404		360,404			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	17,662,219	34,124	2,248	17,698,591		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,338,619	730,581	48,126	2,139,844	18,257,170	5.00
7.00	00700	OPERATION OF PLANT	3,352,597	1,345,777	88,652	472,848	5,259,874	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	464,136	67,246	4,430	0	535,812	8.00
9.00	00900	HOUSEKEEPING	983,148	39,058	2,573	0	1,024,779	9.00
10.00	01000	DIETARY	530,547	141,882	9,346	110,674	792,449	10.00
11.00	01100	CAFETERIA	208,746	38,763	2,553	92,751	342,813	11.00
13.00	01300	NURSING ADMINISTRATION	3,038,354	80,946	5,332	821,464	3,946,096	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,076,375	140,604	9,262	185,075	1,411,316	14.00
15.00	01500	PHARMACY	4,729,943	30,704	2,023	0	4,762,670	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	871,637	20,522	1,352	228,602	1,122,113	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,685,667	572,659	37,723	1,919,088	9,215,137	30.00
31.00	03100	INTENSIVE CARE UNIT	2,725,171	228,038	15,022	597,735	3,565,966	31.00
43.00	04300	NURSERY	686,829	60,307	3,973	192,926	944,035	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,272,640	420,084	27,672	1,843,917	6,564,313	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	216,311	30,645	2,019	60,760	309,735	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,804,222	222,553	14,660	664,103	3,705,538	54.00
57.00	05700	CT SCAN	553,283	8,610	567	67,776	630,236	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	353,389	10,516	693	48,576	413,174	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	5,850,345	162,384	10,697	701,044	6,724,470	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,446,087	48,552	3,198	285,798	1,783,635	65.00
66.00	06600	PHYSICAL THERAPY	1,613,633	21,092	1,389	434,195	2,070,309	66.00
67.00	06700	OCCUPATIONAL THERAPY	249,831	3,420	225	73,784	327,260	67.00
68.00	06800	SPEECH PATHOLOGY	93,517	3,794	250	27,709	125,270	68.00
69.00	06900	ELECTROCARDIOLOGY	413,573	0	0	66,514	480,087	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,401,099	0	0	0	1,401,099	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,351,239	0	0	0	8,351,239	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	192,852	13,976	921	54,640	262,389	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,483,649	0	0	1,473,023	6,956,672	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,198,149	0	0	2,754,843	11,952,992	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,057,151	0	0	256,869	1,314,020	88.02
91.00	09100	EMERGENCY	5,163,705	207,732	13,684	946,406	6,331,527	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,493,754	0	0	371,781	1,865,535	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	722,099	0	0	167,512	889,611	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,828,750	4,684,569	308,590	17,060,257	113,639,341	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,023	1,121	0	18,144	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,070,410	0	0	502,262	2,572,672	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	88,894	0	18,926	0	107,820	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	206,593	0	0	0	206,593	194.05
194.06	07956	DR AFZAL	7,203	0	0	0	7,203	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	411,560	482,238	31,767	81,486	1,007,051	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	469	0	0	0	469	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	65,512	0	0	0	65,512	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	1,884,368	0	0	54,586	1,938,954	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	119,563,759	5,183,830	360,404	17,698,591	119,563,759	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 3:43 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,257,170					5.00
7.00	00700	OPERATION OF PLANT	947,919	6,207,793				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	96,562	94,842	727,216			8.00
9.00	00900	HOUSEKEEPING	184,683	55,086	30,858	1,295,406		9.00
10.00	01000	DIETARY	142,813	200,107	8,288	42,791	1,186,448	10.00
11.00	01100	CAFETERIA	61,781	54,671	0	11,691	0	11.00
13.00	01300	NURSING ADMINISTRATION	711,154	114,165	0	24,413	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	254,343	198,305	0	42,405	0	14.00
15.00	01500	PHARMACY	858,314	43,304	0	9,260	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	202,224	28,943	0	6,189	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,660,724	807,665	147,175	172,710	928,663	30.00
31.00	03100	INTENSIVE CARE UNIT	642,648	321,619	33,095	68,775	257,785	31.00
43.00	04300	NURSERY	170,131	85,055	10,772	18,188	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,183,001	592,477	130,748	126,694	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	55,820	43,221	3,392	9,242	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	667,801	313,884	52,918	67,121	0	54.00
57.00	05700	CT SCAN	113,579	12,143	0	2,597	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	74,461	14,832	0	3,172	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,211,864	229,023	920	48,974	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	321,441	90,378	0	19,326	0	65.00
66.00	06600	PHYSICAL THERAPY	373,105	725,965	13,605	155,239	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	58,978	4,824	2,410	1,032	0	67.00
68.00	06800	SPEECH PATHOLOGY	22,576	5,351	0	1,144	0	68.00
69.00	06900	ELECTROCARDIOLOGY	86,520	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	252,502	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,505,035	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	47,287	19,711	0	4,215	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,253,711	437,087	4,521	93,466	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,154,130	1,129,811	2,180	241,597	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	236,809	141,389	0	30,234	0	88.02
91.00	09100	EMERGENCY	1,141,049	292,981	130,270	62,651	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	336,201	63,487	0	13,576	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	160,323	63,459	0	13,570	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,189,489	6,183,785	571,152	1,290,272	1,186,448	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,270	24,008	0	5,134	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	463,639	0	0	0	0	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	19,431	0	0	0	0	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	37,232	0	13,580	0	0	194.05
194.06	07956	DR AFZAL	1,298	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	5,905	0	0	194.07
194.08	07958	OB DRS	0	0	9,758	0	0	194.08
194.09	07959	THE WATERS	181,488	0	126,821	0	0	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	85	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	11,806	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	349,432	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
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)	18,257,170	6,207,793	727,216	1,295,406	1,186,448	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 3:43 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	470,956					11.00
13.00	01300	NURSING ADMINISTRATION	34,115	4,829,943				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,623	0	1,916,992			14.00
15.00	01500	PHARMACY	0	0	3,175	5,676,723		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,345	0	401	0	1,380,215	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	87,839	874,633	43,640	0	136,185	30.00
31.00	03100	INTENSIVE CARE UNIT	29,812	296,854	17,288	0	66,509	31.00
43.00	04300	NURSERY	7,494	74,621	4,031	0	38,005	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	74,353	740,364	108,425	0	226,130	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,360	23,500	1,269	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,449	0	23,199	0	205,227	54.00
57.00	05700	CT SCAN	3,303	0	14,212	0	79,811	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,487	0	2,719	0	15,202	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	48,464	0	285,130	0	218,529	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	16,141	0	5,333	0	12,668	65.00
66.00	06600	PHYSICAL THERAPY	37,332	0	5,736	0	8,234	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,898	0	17	0	1,267	67.00
68.00	06800	SPEECH PATHOLOGY	1,194	0	2	0	633	68.00
69.00	06900	ELECTROCARDIOLOGY	3,360	0	8,687	0	11,402	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	493,635	0	26,604	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	824,332	0	54,474	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,676,723	0	73.00
76.00	03950	CARDIAC REHAB	3,855	38,387	820	0	1,900	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	813,646	7,735	0	7,601	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,355,030	9,560	0	29,771	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	139,616	2,647	0	0	88.02
91.00	09100	EMERGENCY	47,532	473,292	49,325	0	235,629	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	3,591	0	3,167	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	2,083	0	1,267	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	470,956	4,829,943	1,916,992	5,676,723	1,380,215	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	0	0	0	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06	07956	DR AFZAL	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	0	0	0	0	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	0	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
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)	470,956	4,829,943	1,916,992	5,676,723	1,380,215	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 3:43 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	14,074,371	0	14,074,371		30.00
31.00	03100	INTENSIVE CARE UNIT	5,300,351	0	5,300,351		31.00
43.00	04300	NURSERY	1,352,332	0	1,352,332		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	9,746,505	0	9,746,505		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	448,539	0	448,539		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,072,137	0	5,072,137		54.00
57.00	05700	CT SCAN	855,881	0	855,881		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	526,047	0	526,047		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	8,767,374	0	8,767,374		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	2,248,922	0	2,248,922		65.00
66.00	06600	PHYSICAL THERAPY	3,389,525	0	3,389,525		66.00
67.00	06700	OCCUPATIONAL THERAPY	399,686	0	399,686		67.00
68.00	06800	SPEECH PATHOLOGY	156,170	0	156,170		68.00
69.00	06900	ELECTROCARDIOLOGY	590,056	0	590,056		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,173,840	0	2,173,840		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,735,080	0	10,735,080		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,676,723	0	5,676,723		73.00
76.00	03950	CARDIAC REHAB	378,564	0	378,564		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	9,574,439	0	9,574,439		88.00
88.01	08801	RURAL HEALTH CLINIC II	16,875,071	0	16,875,071		88.01
88.02	08802	RURAL HEALTH CLINIC III	1,864,715	0	1,864,715		88.02
91.00	09100	EMERGENCY	8,764,256	0	8,764,256		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	2,285,557	0	2,285,557		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	1,130,313	0	1,130,313		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	112,386,454	0	112,386,454		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	50,556	0	50,556		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,036,311	0	3,036,311		192.00
194.00	07950	HOSPITALIST	0	0	0		194.00
194.01	07951	RENTAL	127,251	0	127,251		194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	257,405	0	257,405		194.05
194.06	07956	DR AFZAL	8,501	0	8,501		194.06
194.07	07957	PHILLIPS HALL	5,905	0	5,905		194.07
194.08	07958	OB DRS	9,758	0	9,758		194.08
194.09	07959	THE WATERS	1,315,360	0	1,315,360		194.09
194.10	07960	CAMBRIDGE CITY	0	0	0		194.10
194.11	07961	WELL BEING	554	0	554		194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	77,318	0	77,318		194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0		194.13
194.14	07964	HENRY COUNTY RADIOLOGY	2,288,386	0	2,288,386		194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0		194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0		194.16
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	119,563,759	0	119,563,759		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/26/2022 3:43 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	34,124	2,248	36,372	36,372	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	730,581	48,126	778,707	4,395	5.00
7.00	00700	OPERATION OF PLANT	0	1,345,777	88,652	1,434,429	971	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	67,246	4,430	71,676	0	8.00
9.00	00900	HOUSEKEEPING	0	39,058	2,573	41,631	0	9.00
10.00	01000	DIETARY	0	141,882	9,346	151,228	227	10.00
11.00	01100	CAFETERIA	0	38,763	2,553	41,316	191	11.00
13.00	01300	NURSING ADMINISTRATION	0	80,946	5,332	86,278	1,687	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	140,604	9,262	149,866	380	14.00
15.00	01500	PHARMACY	0	30,704	2,023	32,727	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,522	1,352	21,874	470	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	572,659	37,723	610,382	3,942	30.00
31.00	03100	INTENSIVE CARE UNIT	0	228,038	15,022	243,060	1,228	31.00
43.00	04300	NURSERY	0	60,307	3,973	64,280	396	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	420,084	27,672	447,756	3,787	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	30,645	2,019	32,664	125	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	222,553	14,660	237,213	1,364	54.00
57.00	05700	CT SCAN	0	8,610	567	9,177	139	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	10,516	693	11,209	100	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	162,384	10,697	173,081	1,440	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	48,552	3,198	51,750	587	65.00
66.00	06600	PHYSICAL THERAPY	0	21,092	1,389	22,481	892	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,420	225	3,645	152	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,794	250	4,044	57	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	137	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
76.00	03950	CARDIAC REHAB	0	13,976	921	14,897	112	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	3,025	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	5,677	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	528	88.02
91.00	09100	EMERGENCY	0	207,732	13,684	221,416	1,944	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	764	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	344	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,684,569	308,590	4,993,159	35,061	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,023	1,121	18,144	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,032	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	18,926	18,926	0	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06	07956	DR AFZAL	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	482,238	31,767	514,005	167	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	0	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0	112	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,183,830	360,404	5,544,234	36,372	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 3:43 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	783,102					5.00
7.00	00700	OPERATION OF PLANT	40,659	1,476,059				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,142	22,551	98,369			8.00
9.00	00900	HOUSEKEEPING	7,922	13,098	4,174	66,825		9.00
10.00	01000	DIETARY	6,126	47,581	1,121	2,207	208,490	10.00
11.00	01100	CAFETERIA	2,650	12,999	0	603	0	11.00
13.00	01300	NURSING ADMINISTRATION	30,503	27,146	0	1,259	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,909	47,152	0	2,188	0	14.00
15.00	01500	PHARMACY	36,815	10,297	0	478	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,674	6,882	0	319	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	71,233	192,043	19,908	8,909	163,190	30.00
31.00	03100	INTENSIVE CARE UNIT	27,565	76,473	4,477	3,548	45,300	31.00
43.00	04300	NURSERY	7,297	20,224	1,457	938	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,742	140,876	17,686	6,536	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,394	10,277	459	477	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,644	74,634	7,158	3,462	0	54.00
57.00	05700	CT SCAN	4,872	2,887	0	134	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,194	3,527	0	164	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	51,980	54,456	124	2,526	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	13,787	21,490	0	997	0	65.00
66.00	06600	PHYSICAL THERAPY	16,003	172,616	1,840	8,008	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,530	1,147	326	53	0	67.00
68.00	06800	SPEECH PATHOLOGY	968	1,272	0	59	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,711	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,830	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	64,555	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	2,028	4,687	0	217	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	53,775	103,928	612	4,822	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	92,400	268,639	295	12,464	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	10,157	33,619	0	1,560	0	88.02
91.00	09100	EMERGENCY	48,943	69,664	17,621	3,232	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	14,421	15,096	0	700	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	6,877	15,089	0	700	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	737,306	1,470,350	77,258	66,560	208,490	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	140	5,709	0	265	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,887	0	0	0	0	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	833	0	0	0	0	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	1,597	0	1,837	0	0	194.05
194.06	07956	DR AFZAL	56	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	799	0	0	194.07
194.08	07958	OB DRS	0	0	1,320	0	0	194.08
194.09	07959	THE WATERS	7,785	0	17,155	0	0	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	4	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	506	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	14,988	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
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)	783,102	1,476,059	98,369	66,825	208,490	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/26/2022 3:43 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	57,759					11.00
13.00	01300	NURSING ADMINISTRATION	4,184	151,057				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,303	0	211,798			14.00
15.00	01500	PHARMACY	0	0	351	80,668		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,495	0	44	0	40,758	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,774	27,354	4,822	0	4,022	30.00
31.00	03100	INTENSIVE CARE UNIT	3,656	9,284	1,910	0	1,964	31.00
43.00	04300	NURSERY	919	2,334	445	0	1,122	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,119	23,155	11,979	0	6,678	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	289	735	140	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,470	0	2,563	0	6,060	54.00
57.00	05700	CT SCAN	405	0	1,570	0	2,357	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	305	0	300	0	449	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	5,944	0	31,503	0	6,453	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,980	0	589	0	374	65.00
66.00	06600	PHYSICAL THERAPY	4,578	0	634	0	243	66.00
67.00	06700	OCCUPATIONAL THERAPY	478	0	2	0	37	67.00
68.00	06800	SPEECH PATHOLOGY	146	0	0	0	19	68.00
69.00	06900	ELECTROCARDIOLOGY	412	0	960	0	337	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	54,540	0	786	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	91,075	0	1,609	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	80,668	0	73.00
76.00	03950	CARDIAC REHAB	473	1,201	91	0	56	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	25,447	855	0	224	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	42,378	1,056	0	879	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	4,367	292	0	0	88.02
91.00	09100	EMERGENCY	5,829	14,802	5,450	0	6,958	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	397	0	94	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	230	0	37	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	57,759	151,057	211,798	80,668	40,758	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	0	0	0	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06	07956	DR AFZAL	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	0	0	0	0	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	0	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
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)	57,759	151,057	211,798	80,668	40,758	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 3:43 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,116,579	0	1,116,579		30.00
31.00	03100	INTENSIVE CARE UNIT	418,465	0	418,465		31.00
43.00	04300	NURSERY	99,412	0	99,412		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	718,314	0	718,314		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	47,560	0	47,560		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	365,568	0	365,568		54.00
57.00	05700	CT SCAN	21,541	0	21,541		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	19,248	0	19,248		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	327,507	0	327,507		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	91,554	0	91,554		65.00
66.00	06600	PHYSICAL THERAPY	227,295	0	227,295		66.00
67.00	06700	OCCUPATIONAL THERAPY	8,370	0	8,370		67.00
68.00	06800	SPEECH PATHOLOGY	6,565	0	6,565		68.00
69.00	06900	ELECTROCARDIOLOGY	5,557	0	5,557		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,156	0	66,156		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	157,239	0	157,239		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	80,668	0	80,668		73.00
76.00	03950	CARDIAC REHAB	23,762	0	23,762		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	192,688	0	192,688		88.00
88.01	08801	RURAL HEALTH CLINIC II	423,788	0	423,788		88.01
88.02	08802	RURAL HEALTH CLINIC III	50,523	0	50,523		88.02
91.00	09100	EMERGENCY	395,859	0	395,859		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	31,472	0	31,472		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	23,277	0	23,277		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,918,967	0	4,918,967		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	24,258	0	24,258		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,919	0	20,919		192.00
194.00	07950	HOSPITALIST	0	0	0		194.00
194.01	07951	RENTAL	19,759	0	19,759		194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	3,434	0	3,434		194.05
194.06	07956	DR AFZAL	56	0	56		194.06
194.07	07957	PHILLIPS HALL	799	0	799		194.07
194.08	07958	OB DRS	1,320	0	1,320		194.08
194.09	07959	THE WATERS	539,112	0	539,112		194.09
194.10	07960	CAMBRIDGE CITY	0	0	0		194.10
194.11	07961	WELL BEING	4	0	4		194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	506	0	506		194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0		194.13
194.14	07964	HENRY COUNTY RADIOLOGY	15,100	0	15,100		194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0		194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0		194.16
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	5,544,234	0	5,544,234		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 3:43 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	263,718					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		278,334				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,736	1,736	55,839,913			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	37,167	37,167	6,751,319	-18,257,170	101,306,589	5.00
7.00	00700	OPERATION OF PLANT	68,464	68,464	1,491,861	0	5,259,874	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,421	3,421	0	0	535,812	8.00
9.00	00900	HOUSEKEEPING	1,987	1,987	0	0	1,024,779	9.00
10.00	01000	DIETARY	7,218	7,218	349,183	0	792,449	10.00
11.00	01100	CAFETERIA	1,972	1,972	292,633	0	342,813	11.00
13.00	01300	NURSING ADMINISTRATION	4,118	4,118	2,591,761	0	3,946,096	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,153	7,153	583,921	0	1,411,316	14.00
15.00	01500	PHARMACY	1,562	1,562	0	0	4,762,670	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,044	1,044	721,252	0	1,122,113	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,133	29,133	6,054,823	0	9,215,137	30.00
31.00	03100	INTENSIVE CARE UNIT	11,601	11,601	1,885,886	0	3,565,966	31.00
43.00	04300	NURSERY	3,068	3,068	608,690	0	944,035	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,371	21,371	5,817,654	0	6,564,313	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,559	1,559	191,702	0	309,735	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,322	11,322	2,095,278	0	3,705,538	54.00
57.00	05700	CT SCAN	438	438	213,836	0	630,236	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	535	535	153,260	0	413,174	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	8,261	8,261	2,211,829	0	6,724,470	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,470	2,470	901,706	0	1,783,635	65.00
66.00	06600	PHYSICAL THERAPY	1,073	1,073	1,369,907	0	2,070,309	66.00
67.00	06700	OCCUPATIONAL THERAPY	174	174	232,791	0	327,260	67.00
68.00	06800	SPEECH PATHOLOGY	193	193	87,422	0	125,270	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	209,856	0	480,087	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,401,099	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	8,351,239	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	711	711	172,391	0	262,389	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	4,647,464	0	6,956,672	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	8,691,617	0	11,952,992	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	810,435	0	1,314,020	88.02
91.00	09100	EMERGENCY	10,568	10,568	2,985,961	0	6,331,527	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	1,172,987	0	1,865,535	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	528,508	0	889,611	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	238,319	238,319	53,825,933	-18,257,170	95,382,171	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	866	866	0	0	18,144	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,584,664	0	2,572,672	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	14,616	0	0	107,820	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	206,593	194.05
194.06	07956	DR AFZAL	0	0	0	0	7,203	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	24,533	24,533	257,093	0	1,007,051	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	0	0	0	0	469	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	65,512	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	172,223	0	1,938,954	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 3:43 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	5,183,830	360,404	17,698,591		18,257,170	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.656717	1.294862	0.316952		0.180217	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			36,372		783,102	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000651		0.007730	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: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 3:43 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	223,919					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,421	705,361				8.00
9.00	00900	HOUSEKEEPING	1,987	29,931	218,511			9.00
10.00	01000	DIETARY	7,218	8,039	7,218	9,343		10.00
11.00	01100	CAFETERIA	1,972	0	1,972	0	662,129	11.00
13.00	01300	NURSING ADMINISTRATION	4,118	0	4,118	0	47,963	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,153	0	7,153	0	14,935	14.00
15.00	01500	PHARMACY	1,562	0	1,562	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,044	0	1,044	0	28,604	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,133	142,751	29,133	7,313	123,493	30.00
31.00	03100	INTENSIVE CARE UNIT	11,601	32,100	11,601	2,030	41,914	31.00
43.00	04300	NURSERY	3,068	10,448	3,068	0	10,536	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,371	126,819	21,371	0	104,535	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,559	3,290	1,559	0	3,318	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,322	51,328	11,322	0	51,245	54.00
57.00	05700	CT SCAN	438	0	438	0	4,644	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	535	0	535	0	3,497	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	8,261	892	8,261	0	68,137	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	3,260	0	3,260	0	22,693	65.00
66.00	06600	PHYSICAL THERAPY	26,186	13,196	26,186	0	52,486	66.00
67.00	06700	OCCUPATIONAL THERAPY	174	2,338	174	0	5,480	67.00
68.00	06800	SPEECH PATHOLOGY	193	0	193	0	1,679	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	4,724	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
76.00	03950	CARDIAC REHAB	711	0	711	0	5,420	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	15,766	4,385	15,766	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	40,753	2,114	40,753	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,100	0	5,100	0	0	88.02
91.00	09100	EMERGENCY	10,568	126,355	10,568	0	66,826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,290	0	2,290	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	2,289	0	2,289	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	223,053	553,986	217,645	9,343	662,129	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	866	0	866	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	0	0	0	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	13,172	0	0	0	194.05
194.06	07956	DR AFZAL	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	5,728	0	0	0	194.07
194.08	07958	OB DRS	0	9,465	0	0	0	194.08
194.09	07959	THE WATERS	0	123,010	0	0	0	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	0	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,207,793	727,216	1,295,406	1,186,448	470,956	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.723387	1.030984	5.928333	126.987905	0.711275	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 3:43 pm

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	1,476,059	98,369	66,825	208,490	57,759	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	6.591933	0.139459	0.305820	22.315102	0.087232	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: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 3:43 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	681,959					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,182,541				14.00
15.00	01500	PHARMACY	0	23,492	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,968	0	2,179		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	123,493	322,860	0	215		30.00
31.00	03100	INTENSIVE CARE UNIT	41,914	127,899	0	105		31.00
43.00	04300	NURSERY	10,536	29,820	0	60		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	104,535	802,159	0	357		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,318	9,390	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	171,631	0	324		54.00
57.00	05700	CT SCAN	0	105,144	0	126		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	20,115	0	24		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	2,109,483	0	345		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	39,452	0	20		65.00
66.00	06600	PHYSICAL THERAPY	0	42,438	0	13		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	123	0	2		67.00
68.00	06800	SPEECH PATHOLOGY	0	13	0	1		68.00
69.00	06900	ELECTROCARDIOLOGY	0	64,267	0	18		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,652,062	0	42		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,098,717	0	86		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0		73.00
76.00	03950	CARDIAC REHAB	5,420	6,067	0	3		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	114,882	57,223	0	12		88.00
88.01	08801	RURAL HEALTH CLINIC II	191,322	70,730	0	47		88.01
88.02	08802	RURAL HEALTH CLINIC III	19,713	19,586	0	0		88.02
91.00	09100	EMERGENCY	66,826	364,925	0	372		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	26,565	0	5		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	15,412	0	2		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	681,959	14,182,541	100	2,179		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	HOSPITALIST	0	0	0	0		194.00
194.01	07951	RENTAL	0	0	0	0		194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0		194.05
194.06	07956	DR AFZAL	0	0	0	0		194.06
194.07	07957	PHILLIPS HALL	0	0	0	0		194.07
194.08	07958	OB DRS	0	0	0	0		194.08
194.09	07959	THE WATERS	0	0	0	0		194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0		194.10
194.11	07961	WELL BEING	0	0	0	0		194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0		194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0		194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0		194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0		194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0		194.16
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)	4,829,943	1,916,992	5,676,723	1,380,215		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.082454	0.135166	56,767.230000	633.416705		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 3:43 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
204.00		Cost to be allocated (per Wkst. B, Part II)	151,057	211,798	80,668	40,758		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.221505	0.014934	806.680000	18.704911		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 3:43 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,074,371		14,074,371	0	14,074,371	30.00
31.00	03100	INTENSIVE CARE UNIT	5,300,351		5,300,351	0	5,300,351	31.00
43.00	04300	NURSERY	1,352,332		1,352,332	0	1,352,332	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,746,505		9,746,505	0	9,746,505	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	448,539		448,539	0	448,539	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,072,137		5,072,137	0	5,072,137	54.00
57.00	05700	CT SCAN	855,881		855,881	0	855,881	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	526,047		526,047	0	526,047	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	8,767,374		8,767,374	0	8,767,374	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,248,922	0	2,248,922	0	2,248,922	65.00
66.00	06600	PHYSICAL THERAPY	3,389,525	0	3,389,525	0	3,389,525	66.00
67.00	06700	OCCUPATIONAL THERAPY	399,686	0	399,686	0	399,686	67.00
68.00	06800	SPEECH PATHOLOGY	156,170	0	156,170	0	156,170	68.00
69.00	06900	ELECTROCARDIOLOGY	590,056		590,056	0	590,056	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,173,840		2,173,840	0	2,173,840	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,735,080		10,735,080	0	10,735,080	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,676,723		5,676,723	0	5,676,723	73.00
76.00	03950	CARDIAC REHAB	378,564		378,564	0	378,564	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,574,439		9,574,439	0	9,574,439	88.00
88.01	08801	RURAL HEALTH CLINIC II	16,875,071		16,875,071	0	16,875,071	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,864,715		1,864,715	0	1,864,715	88.02
91.00	09100	EMERGENCY	8,764,256		8,764,256	33,058	8,797,314	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,291,595		2,291,595		2,291,595	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,285,557		2,285,557		2,285,557	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,130,313		1,130,313		1,130,313	116.00
200.00		Subtotal (see instructions)	114,678,049	0	114,678,049	33,058	114,711,107	200.00
201.00		Less Observation Beds	2,291,595		2,291,595		2,291,595	201.00
202.00		Total (see instructions)	112,386,454	0	112,386,454	33,058	112,419,512	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 3:43 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,983,630		11,983,630			30.00
31.00	03100	INTENSIVE CARE UNIT	6,391,432		6,391,432			31.00
43.00	04300	NURSERY	1,774,635		1,774,635			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,100,594	34,771,549	42,872,143	0.227339	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,278,667	1,278,667	0.350786	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,726,160	19,129,544	20,855,704	0.243201	0.000000	54.00
57.00	05700	CT SCAN	3,645,139	33,037,871	36,683,010	0.023332	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	528,538	9,532,671	10,061,209	0.052285	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	11,841,521	38,049,714	49,891,235	0.175730	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	4,888,748	3,150,765	8,039,513	0.279734	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	799,207	4,426,619	5,225,826	0.648610	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	210,438	635,078	845,516	0.472713	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	101,690	221,908	323,598	0.482605	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,576,250	6,003,365	7,579,615	0.077848	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,492,072	11,647,451	17,139,523	0.126832	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,522,230	23,887,025	35,409,255	0.303172	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,016,785	6,626,780	13,643,565	0.416073	0.000000	73.00
76.00	03950	CARDIAC REHAB	25,737	1,320,122	1,345,859	0.281281	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,910,785	4,910,785			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	19,214,658	19,214,658			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,836,665	1,836,665			88.02
91.00	09100	EMERGENCY	6,693,918	48,297,963	54,991,881	0.159374	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,452,760	8,355,447	11,808,207	0.194068	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,155,376	2,155,376			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	708,562	708,562			116.00
200.00		Subtotal (see instructions)	87,771,484	279,198,585	366,970,069			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	87,771,484	279,198,585	366,970,069			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 3:43 pm

Title XVIII | Hospital | PPS

		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	0.227339		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.350786		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.243201		54.00
57.00	05700	CT SCAN	0.023332		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052285		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.175730		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.279734		65.00
66.00	06600	PHYSICAL THERAPY	0.648610		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.472713		67.00
68.00	06800	SPEECH PATHOLOGY	0.482605		68.00
69.00	06900	ELECTROCARDIOLOGY	0.077848		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.126832		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.303172		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.416073		73.00
76.00	03950	CARDIAC REHAB	0.281281		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
91.00	09100	EMERGENCY	0.159975		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.194068		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
114.00	11400	UTILIZATION REVIEW-SNF			114.00
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: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 3:43 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,074,371		14,074,371	0	14,074,371	30.00
31.00	03100	INTENSIVE CARE UNIT	5,300,351		5,300,351	0	5,300,351	31.00
43.00	04300	NURSERY	1,352,332		1,352,332	0	1,352,332	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,746,505		9,746,505	0	9,746,505	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	448,539		448,539	0	448,539	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,072,137		5,072,137	0	5,072,137	54.00
57.00	05700	CT SCAN	855,881		855,881	0	855,881	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	526,047		526,047	0	526,047	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	8,767,374		8,767,374	0	8,767,374	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,248,922	0	2,248,922	0	2,248,922	65.00
66.00	06600	PHYSICAL THERAPY	3,389,525	0	3,389,525	0	3,389,525	66.00
67.00	06700	OCCUPATIONAL THERAPY	399,686	0	399,686	0	399,686	67.00
68.00	06800	SPEECH PATHOLOGY	156,170	0	156,170	0	156,170	68.00
69.00	06900	ELECTROCARDIOLOGY	590,056		590,056	0	590,056	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,173,840		2,173,840	0	2,173,840	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,735,080		10,735,080	0	10,735,080	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,676,723		5,676,723	0	5,676,723	73.00
76.00	03950	CARDIAC REHAB	378,564		378,564	0	378,564	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,574,439		9,574,439	0	9,574,439	88.00
88.01	08801	RURAL HEALTH CLINIC II	16,875,071		16,875,071	0	16,875,071	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,864,715		1,864,715	0	1,864,715	88.02
91.00	09100	EMERGENCY	8,764,256		8,764,256	33,058	8,797,314	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,291,595		2,291,595		2,291,595	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,285,557		2,285,557		2,285,557	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,130,313		1,130,313		1,130,313	116.00
200.00		Subtotal (see instructions)	114,678,049	0	114,678,049	33,058	114,711,107	200.00
201.00		Less Observation Beds	2,291,595		2,291,595		2,291,595	201.00
202.00		Total (see instructions)	112,386,454	0	112,386,454	33,058	112,419,512	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 3:43 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,983,630		11,983,630			30.00
31.00	03100	INTENSIVE CARE UNIT	6,391,432		6,391,432			31.00
43.00	04300	NURSERY	1,774,635		1,774,635			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,100,594	34,771,549	42,872,143	0.227339	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,278,667	1,278,667	0.350786	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,726,160	19,129,544	20,855,704	0.243201	0.000000	54.00
57.00	05700	CT SCAN	3,645,139	33,037,871	36,683,010	0.023332	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	528,538	9,532,671	10,061,209	0.052285	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	11,841,521	38,049,714	49,891,235	0.175730	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	4,888,748	3,150,765	8,039,513	0.279734	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	799,207	4,426,619	5,225,826	0.648610	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	210,438	635,078	845,516	0.472713	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	101,690	221,908	323,598	0.482605	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,576,250	6,003,365	7,579,615	0.077848	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,492,072	11,647,451	17,139,523	0.126832	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,522,230	23,887,025	35,409,255	0.303172	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,016,785	6,626,780	13,643,565	0.416073	0.000000	73.00
76.00	03950	CARDIAC REHAB	25,737	1,320,122	1,345,859	0.281281	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,910,785	4,910,785	1.949676	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	19,214,658	19,214,658	0.878239	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,836,665	1,836,665	1.015272	0.000000	88.02
91.00	09100	EMERGENCY	6,693,918	48,297,963	54,991,881	0.159374	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,452,760	8,355,447	11,808,207	0.194068	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,155,376	2,155,376			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	708,562	708,562			116.00
200.00		Subtotal (see instructions)	87,771,484	279,198,585	366,970,069			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	87,771,484	279,198,585	366,970,069			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 3:43 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
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
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
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
76.00	03950	CARDIAC REHAB	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
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
114.00	11400	UTILIZATION REVIEW-SNF			114.00
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 ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part I Date/Time Prepared: 5/26/2022 3:43 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,116,579	0	1,116,579	8,623	129.49	30.00
31.00	INTENSIVE CARE UNIT	418,465		418,465	2,030	206.14	31.00
43.00	NURSERY	99,412		99,412	435	228.53	43.00
200.00	Total (lines 30 through 199)	1,634,456		1,634,456	11,088		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,833	366,845	30.00
31.00	INTENSIVE CARE UNIT	661	136,259	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	3,494	503,104	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/26/2022 3:43 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	718,314	42,872,143	0.016755	3,288,536	55,099	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	47,560	1,278,667	0.037195	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	365,568	20,855,704	0.017528	764,430	13,399	54.00
57.00	05700	CT SCAN	21,541	36,683,010	0.000587	1,460,066	857	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	19,248	10,061,209	0.001913	211,096	404	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	327,507	49,891,235	0.006564	4,570,189	29,999	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	91,554	8,039,513	0.011388	1,912,931	21,784	65.00
66.00	06600	PHYSICAL THERAPY	227,295	5,225,826	0.043495	372,503	16,202	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,370	845,516	0.009899	103,053	1,020	67.00
68.00	06800	SPEECH PATHOLOGY	6,565	323,598	0.020288	54,457	1,105	68.00
69.00	06900	ELECTROCARDIOLOGY	5,557	7,579,615	0.000733	703,873	516	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,156	17,139,523	0.003860	2,052,471	7,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	157,239	35,409,255	0.004441	5,165,571	22,940	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	80,668	13,643,565	0.005913	2,479,527	14,661	73.00
76.00	03950	CARDIAC REHAB	23,762	1,345,859	0.017656	8,579	151	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	192,688	4,910,785	0.039238	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	423,788	19,214,658	0.022055	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	50,523	1,836,665	0.027508	0	0	88.02
91.00	09100	EMERGENCY	395,859	54,991,881	0.007198	2,789,286	20,077	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	181,801	11,808,207	0.015396	820,579	12,634	92.00
200.00		Total (lines 50 through 199)	3,411,563	343,956,434		26,757,147	218,771	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part III Date/Time Prepared: 5/26/2022 3:43 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	8,623	0.00	2,833	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,030	0.00	661	31.00
43.00	04300	NURSERY		0	435	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	11,088		3,494	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/26/2022 3:43 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
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
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
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: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/26/2022 3:43 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	42,872,143	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,278,667	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,855,704	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	36,683,010	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	10,061,209	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	49,891,235	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,039,513	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,225,826	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	845,516	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	323,598	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	7,579,615	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	17,139,523	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	35,409,255	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,643,565	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	0	0	1,345,859	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,910,785	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	19,214,658	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,836,665	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	54,991,881	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	11,808,207	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	343,956,434		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/26/2022 3:43 pm

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		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	3,288,536	0	8,170,828	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	140,848	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	764,430	0	5,133,500	0	54.00
57.00	05700	CT SCAN	0.000000	1,460,066	0	6,933,466	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	211,096	0	2,082,764	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	4,570,189	0	2,886,543	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	1,912,931	0	619,406	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	372,503	0	33,452	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	103,053	0	3,002	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	54,457	0	5,607	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	703,873	0	1,693,449	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,052,471	0	2,300,537	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	5,165,571	0	7,354,828	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,479,527	0	1,920,161	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	8,579	0	438,347	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
91.00	09100	EMERGENCY	0.000000	2,789,286	0	8,524,570	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	820,579	0	1,905,026	0	92.00
200.00		Total (lines 50 through 199)		26,757,147	0	50,146,334	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/26/2022 3:43 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.227339	8,170,828	0	0	1,857,548	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.350786	140,848	0	0	49,408	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.243201	5,133,500	0	0	1,248,472	54.00
57.00	05700	CT SCAN	0.023332	6,933,466	0	0	161,772	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052285	2,082,764	0	0	108,897	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.175730	2,886,543	0	0	507,252	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.279734	619,406	0	0	173,269	65.00
66.00	06600	PHYSICAL THERAPY	0.648610	33,452	0	0	21,697	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.472713	3,002	0	0	1,419	67.00
68.00	06800	SPEECH PATHOLOGY	0.482605	5,607	0	0	2,706	68.00
69.00	06900	ELECTROCARDIOLOGY	0.077848	1,693,449	0	0	131,832	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.126832	2,300,537	0	0	291,782	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.303172	7,354,828	0	0	2,229,778	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.416073	1,920,161	0	410	798,927	73.00
76.00	03950	CARDIAC REHAB	0.281281	438,347	0	0	123,299	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
91.00	09100	EMERGENCY	0.159374	8,524,570	0	0	1,358,595	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.194068	1,905,026	0	0	369,705	92.00
200.00		Subtotal (see instructions)		50,146,334	0	410	9,436,358	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		50,146,334	0	410	9,436,358	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/26/2022 3:43 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	171		73.00
76.00	03950	CARDIAC REHAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	171		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	171		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 3:43 pm

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	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)	8,623	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,623	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)	7,219	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,833	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	14,074,371	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	14,074,371	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)	14,074,371	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)	1,632.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,623,994	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	4,623,994	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 3:43 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,300,351	2,030	2,611.01	661	1,725,878	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)	6,154,171	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	12,504,043	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)	503,104	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	218,771	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	721,875	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	11,782,168	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)	1,404	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,632.19	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,291,595	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 3:43 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,116,579	14,074,371	0.079334	2,291,595	181,801	90.00
91.00	Nursing Program cost	0	14,074,371	0.000000	2,291,595	0	91.00
92.00	Allied health cost	0	14,074,371	0.000000	2,291,595	0	92.00
93.00	All other Medical Education	0	14,074,371	0.000000	2,291,595	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0030	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/26/2022 3:43 pm
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,623	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,623	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)	7,219	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	267	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)	435	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	14,074,371	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	14,074,371	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)	14,074,371	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)	1,632.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	435,795	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)	435,795	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 3:43 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,352,332	435	3,108.81	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,300,351	2,030	2,611.01	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	224,996	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	660,791	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)	1,404	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,632.19	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,291,595	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 3:43 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,116,579	14,074,371	0.079334	2,291,595	181,801	90.00
91.00	Nursing Program cost	0	14,074,371	0.000000	2,291,595	0	91.00
92.00	Allied health cost	0	14,074,371	0.000000	2,291,595	0	92.00
93.00	All other Medical Education	0	14,074,371	0.000000	2,291,595	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 3:43 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,743,950		30.00
31.00	03100	INTENSIVE CARE UNIT		2,156,940		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.227339	3,288,536	747,612	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.350786	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.243201	764,430	185,910	54.00
57.00	05700	CT SCAN	0.023332	1,460,066	34,066	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052285	211,096	11,037	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.175730	4,570,189	803,119	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.279734	1,912,931	535,112	65.00
66.00	06600	PHYSICAL THERAPY	0.648610	372,503	241,609	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.472713	103,053	48,714	67.00
68.00	06800	SPEECH PATHOLOGY	0.482605	54,457	26,281	68.00
69.00	06900	ELECTROCARDIOLOGY	0.077848	703,873	54,795	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.126832	2,052,471	260,319	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.303172	5,165,571	1,566,056	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.416073	2,479,527	1,031,664	73.00
76.00	03950	CARDIAC REHAB	0.281281	8,579	2,413	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100	EMERGENCY	0.159975	2,789,286	446,216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.194068	820,579	159,248	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		26,757,147	6,154,171	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)		26,757,147		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 3:43 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		292,184		30.00
31.00	03100	INTENSIVE CARE UNIT		167,268		31.00
43.00	04300	NURSERY		203,105		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.227339	167,328	38,040	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.350786	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.243201	26,162	6,363	54.00
57.00	05700	CT SCAN	0.023332	64,809	1,512	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052285	8,774	459	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.175730	257,535	45,257	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.279734	71,636	20,039	65.00
66.00	06600	PHYSICAL THERAPY	0.648610	4,791	3,107	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.472713	1,478	699	67.00
68.00	06800	SPEECH PATHOLOGY	0.482605	546	264	68.00
69.00	06900	ELECTROCARDIOLOGY	0.077848	22,187	1,727	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.126832	159,027	20,170	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.303172	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.416073	149,218	62,086	73.00
76.00	03950	CARDIAC REHAB	0.281281	275	77	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.949676	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.878239	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.015272	0	0	88.02
91.00	09100	EMERGENCY	0.159374	158,092	25,196	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.194068	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,091,858	224,996	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)		1,091,858		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/26/2022 3:43 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5,647,746	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,939,860	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	24,941	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	536	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	44.03	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.25	30.00
31.00	Percentage of Medicaid patient days (see instructions)	17.47	31.00
32.00	Sum of lines 30 and 31	21.72	32.00
33.00	Allowable disproportionate share percentage (see instructions)	7.14	33.00
34.00	Disproportionate share adjustment (see instructions)	135,439	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Date/Time Prepared: 5/26/2022 3:43 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	444,600	590,026	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	332,536	148,719	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	481,255		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	8,229,777		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	9,656,274		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	9,299,650	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	574,682	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	246,902	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	10,121,234	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	10,121,234	61.00
62.00	Deductibles billed to program beneficiaries	990,020	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	67,767	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	44,049	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	41,746	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	9,175,263	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	3,119	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	-27,970	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	22,713	70.93
70.94	HRR adjustment amount (see instructions)	-204,334	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/26/2022 3:43 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2021	864,335	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2022	301,637	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,134,763	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		10,126,566	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		8,197	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		174,683	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	800,206	269,667	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.0038973054	1.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	3,119	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9700	0.9853	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-24,006	-3,964	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/26/2022 3:43 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,647,746	0	5,647,746		5,647,746	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,939,860	0		1,939,860	1,939,860	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	24,941	0	24,941		24,941	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	536	0		536	536	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0714	0.0714	0.0714	0.0714		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	135,439	0	100,812	34,627	135,439	11.00
11.01	Uncompensated care payments	36.00	481,255	0	332,536	148,719	481,255	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	8,229,777	0	6,106,035	2,123,742	8,229,777	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	9,656,274	0	7,224,083	2,432,191	9,656,274	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,299,650	0	6,944,571	2,355,079	9,299,650	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 5/26/2022 3:43 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	574,682	0	431,089	143,593	574,682	16.00
17.00	Special add-on payments for new technologies	54.00	246,902	0	180,114	66,788	246,902	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	7,555,774	2,565,460	10,121,234	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	571,417	0	427,870	143,547	571,417	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	3,265	0	3,219	46	3,265	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	574,682	0	431,089	143,593	574,682	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.114394	0.117576		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			864,335		864,335	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				301,637	301,637	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/26/2022 3:43 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,647,746	5,647,746		5,647,746	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,939,860		1,939,860	1,939,860	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	24,941	24,941		24,941	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	536		536	536	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0714	0.0714	0.0714		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	135,439	100,812	34,627	135,439	11.00
11.01	Uncompensated care payments	36.00	481,255	332,536	148,719	481,255	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	8,229,777	6,106,035	2,123,742	8,229,777	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	9,656,274	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,299,650	7,175,908	2,123,742	9,299,650	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	574,682	431,089	143,593	574,682	16.00
17.00	Special add-on payments for new technologies	54.00	246,902	180,113	66,789	246,902	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			7,787,110	2,334,124	10,121,234	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/26/2022 3:43 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	571,417	427,870	143,547	571,417	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	3,265	3,219	46	3,265	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	574,682	431,089	143,593	574,682	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	864,335	864,335		864,335	28.00
29.00	Low volume adjustment on or after October 1	70.97	301,637		301,637	301,637	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	22,713	22,713	0	22,713	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	3,119	3,119	0	3,119	30.01
31.00	HRR adjustment (see instructions)	70.94	-204,334	-174,836	-29,498	-204,334	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-27,970	-24,006	-3,964	-27,970	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 3:43 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	171	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	9,436,358	2.00
3.00	OPPS payments	9,095,842	3.00
4.00	Outlier payment (see instructions)	9,026	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)	171	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	410	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)	410	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)	410	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	239	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)	171	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)	9,104,868	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,476,653	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)	7,628,386	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)	7,628,386	30.00
31.00	Primary payer payments	1,909	31.00
32.00	Subtotal (line 30 minus line 31)	7,626,477	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)	162,581	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	105,678	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	144,819	36.00
37.00	Subtotal (see instructions)	7,732,155	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)	7,732,155	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	7,808,204	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)	-76,049	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: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I Date/Time Prepared: 5/26/2022 3:43 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		10,126,566		7,626,401	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	12/01/2021	181,803	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		181,803	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)		10,126,566		7,808,204	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		8,197		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		76,049	6.02
7.00	Total Medicare program liability (see instructions)		10,134,763		7,732,155	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: 15-0030	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/26/2022 3:43 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (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	Provider CCN: 15-0030	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2022 3:43 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	660,791		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)	660,791	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)	660,791	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	662,558		8.00
9.00	Ancillary service charges	1,091,858	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)	1,754,416	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)	1,754,416	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,093,625	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)	660,791	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)	660,791	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)	660,791	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)	660,791	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	660,791	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)	660,791	0	40.00
41.00	Interim payments	761,667	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-100,876	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: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/26/2022 3:43 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	15,687,064	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	19,085,706	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,213,011	0	0	0	7.00
8.00	Prepaid expenses	1,140,429	0	0	0	8.00
9.00	Other current assets	-3,066,189	0	0	0	9.00
10.00	Due from other funds	84,220,564	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	118,280,585	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	46,000	0	0	0	12.00
13.00	Land improvements	1,514,802	0	0	0	13.00
14.00	Accumulated depreciation	-1,003,178	0	0	0	14.00
15.00	Buildings	39,705,260	0	0	0	15.00
16.00	Accumulated depreciation	-31,297,081	0	0	0	16.00
17.00	Leasehold improvements	1,898,222	0	0	0	17.00
18.00	Accumulated depreciation	-1,159,278	0	0	0	18.00
19.00	Fixed equipment	21,978,177	0	0	0	19.00
20.00	Accumulated depreciation	-12,848,383	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	40,255,413	0	0	0	23.00
24.00	Accumulated depreciation	-25,852,391	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)	33,237,563	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	21,909,475	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	7,867,014	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	29,776,489	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	181,294,637	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,795,988	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,443,435	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,067,220	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	67,731,788	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	82,038,431	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	11,082,399	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,082,399	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	93,120,830	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	88,173,807				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)	88,173,807	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	181,294,637	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 | Date/Time Prepared: 5/26/2022 3:43 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		81,278,930		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,894,877				2.00
3.00	Total (sum of line 1 and line 2)		88,173,807		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)		88,173,807		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		88,173,807		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	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2022 3:43 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	14,069,920		14,069,920	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)	14,069,920		14,069,920	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	7,558,475		7,558,475	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)	7,558,475		7,558,475	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	21,628,395		21,628,395	17.00
18.00	Ancillary services	55,167,976	206,440,113	261,608,089	18.00
19.00	Outpatient services	6,693,918	48,301,966	54,995,884	19.00
20.00	RURAL HEALTH CLINIC	0	4,910,785	4,910,785	20.00
20.01	RURAL HEALTH CLINIC II	0	19,214,658	19,214,658	20.01
20.02	RURAL HEALTH CLINIC III	0	1,836,665	1,836,665	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,155,376	2,155,376	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	708,562	708,562	26.00
27.00	NON-REIMBURSEABLE	3,869	14,635,147	14,639,016	27.00
27.01	PRO FEES	4,004,914	6,807,633	10,812,547	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	87,499,072	305,010,905	392,509,977	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		132,652,272		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)		132,652,272		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-3 | Date/Time Prepared: 5/26/2022 3:43 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	392,509,977	1.00
2.00	Less contractual allowances and discounts on patients' accounts	260,900,479	2.00
3.00	Net patient revenues (line 1 minus line 2)	131,609,498	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	132,652,272	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,042,774	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,128,374	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 OPREATING INCOME	5,153,828	24.00
24.01	NON-OPERATING INCOME	71,291	24.01
24.50	COVID-19 PHE Funding	1,584,158	24.50
25.00	Total other income (sum of lines 6-24)	7,937,651	25.00
26.00	Total (line 5 plus line 25)	6,894,877	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)	6,894,877	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2021 To 12/31/2021 | Worksheet H | Date/Time Prepared: 5/26/2022 3:43 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	128,184	0	74,594	0	274,257	477,035	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	599,744	0	0	0	0	599,744	6.00
7.00	Physical Therapy	344,242	0	0	0	0	344,242	7.00
8.00	Occupational Therapy	35,548	0	0	0	0	35,548	8.00
9.00	Speech Pathology	12,505	0	0	0	0	12,505	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	25,578	0	0	0	0	25,578	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,145,801	0	74,594	0	274,257	1,494,652	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	14,445	491,480	-15,343	476,137			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	599,744	0	599,744			6.00
7.00	Physical Therapy	0	344,242	0	344,242			7.00
8.00	Occupational Therapy	0	35,548	0	35,548			8.00
9.00	Speech Pathology	0	12,505	0	12,505			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	25,578	0	25,578			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	14,445	1,509,097	-15,343	1,493,754			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2021 To 12/31/2021 | Worksheet H-1 Part I | Date/Time Prepared: 5/26/2022 3:43 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	476,137	0	0	0	0	476,137	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	599,744	0	0	0	0	599,744	6.00
7.00	Physical Therapy	344,242	0	0	0	0	344,242	7.00
8.00	Occupational Therapy	35,548	0	0	0	0	35,548	8.00
9.00	Speech Pathology	12,505	0	0	0	0	12,505	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	25,578	0	0	0	0	25,578	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,493,754	0	0	0	0	1,493,754	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	476,137		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	280,616	880,360	6.00
7.00	Physical Therapy	161,069	505,311	7.00
8.00	Occupational Therapy	16,633	52,181	8.00
9.00	Speech Pathology	5,851	18,356	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	11,968	37,546	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		1,493,754	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2021 To 12/31/2021 | Worksheet H-1 Part II | Date/Time Prepared: 5/26/2022 3:43 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-476,137	1,017,617	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	599,744	6.00
7.00	Physical Therapy	0	0	0	0	0	344,242	7.00
8.00	Occupational Therapy	0	0	0	0	0	35,548	8.00
9.00	Speech Pathology	0	0	0	0	0	12,505	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	25,578	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-476,137	1,017,617	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		476,137	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.467894	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0030
HHA CCN: 15-7430

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

Worksheet H-2 Part I
Date/Time Prepared: 5/26/2022 3:43 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	0	371,781	371,781	67,001	1.00
2.00	Skilled Nursing Care	880,360	0	0	0	880,360	158,656	2.00
3.00	Physical Therapy	505,311	0	0	0	505,311	91,066	3.00
4.00	Occupational Therapy	52,181	0	0	0	52,181	9,404	4.00
5.00	Speech Pathology	18,356	0	0	0	18,356	3,308	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	37,546	0	0	0	37,546	6,766	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,493,754	0	0	371,781	1,865,535	336,201	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	63,487	0	13,576	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	63,487	0	13,576	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2021 To 12/31/2021 | Worksheet H-2 Part I | Date/Time Prepared: 5/26/2022 3:43 pm

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	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	3,591	0	3,167	522,603	0	522,603	1.00
2.00	Skilled Nursing Care	0	0	0	1,039,016	0	1,039,016	2.00
3.00	Physical Therapy	0	0	0	596,377	0	596,377	3.00
4.00	Occupational Therapy	0	0	0	61,585	0	61,585	4.00
5.00	Speech Pathology	0	0	0	21,664	0	21,664	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	44,312	0	44,312	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	3,591	0	3,167	2,285,557	0	2,285,557	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	308,001	1,347,017					2.00
3.00	Physical Therapy	176,788	773,165					3.00
4.00	Occupational Therapy	18,256	79,841					4.00
5.00	Speech Pathology	6,422	28,086					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	13,136	57,448					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	522,603	2,285,557					20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.296436						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2021 To 12/31/2021 | Worksheet H-2 Part II | Date/Time Prepared: 5/26/2022 3:43 pm

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	0	0	1,172,987	0	371,781	2,290	1.00
2.00	Skilled Nursing Care	0	0	0	0	880,360	0	2.00
3.00	Physical Therapy	0	0	0	0	505,311	0	3.00
4.00	Occupational Therapy	0	0	0	0	52,181	0	4.00
5.00	Speech Pathology	0	0	0	0	18,356	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	37,546	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	1,172,987		1,865,535	2,290	20.00
21.00	Total cost to be allocated	0	0	371,781		336,201	63,487	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.316952		0.180217	27.723581	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	2,290	0	0	0	26,565	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	2,290	0	0	0	26,565	20.00
21.00	Total cost to be allocated	0	13,576	0	0	0	3,591	21.00
22.00	Unit cost multiplier	0.000000	5.928384	0.000000	0.000000	0.000000	0.135178	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2021 To 12/31/2021 | Worksheet H-2 Part II | Date/Time Prepared: 5/26/2022 3:43 pm

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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)			
		15.00	16.00			
1.00	Administrative and General	0	5			1.00
2.00	Skilled Nursing Care	0	0			2.00
3.00	Physical Therapy	0	0			3.00
4.00	Occupational Therapy	0	0			4.00
5.00	Speech Pathology	0	0			5.00
6.00	Medical Social Services	0	0			6.00
7.00	Home Health Aide	0	0			7.00
8.00	Supplies (see instructions)	0	0			8.00
9.00	Drugs	0	0			9.00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18.00
19.00	All Others (specify)	0	0			19.00
19.50	Telemedicine	0	0			19.50
20.00	Total (sum of lines 1-19)	0	5			20.00
21.00	Total cost to be allocated	0	3,167			21.00
22.00	Unit cost multiplier	0.000000	633.400000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2021 To 12/31/2021 | Worksheet H-3 Part I | Date/Time Prepared: 5/26/2022 3:43 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,347,017		1,347,017	4,232	318.29	1.00
2.00	Physical Therapy	3.00	773,165	0	773,165	2,636	293.31	2.00
3.00	Occupational Therapy	4.00	79,841	0	79,841	805	99.18	3.00
4.00	Speech Pathology	5.00	28,086	0	28,086	157	178.89	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	57,448		57,448	1,865	30.80	6.00
7.00	Total (sum of lines 1-6)		2,285,557	0	2,285,557	9,695		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		17140	0	3			8.00
8.01	Skilled Nursing Care		34620	0	36			8.01
8.02	Skilled Nursing Care		99915	0	1,253			8.02
9.00	Physical Therapy		17140	0	6			9.00
9.01	Physical Therapy		34620	0	74			9.01
9.02	Physical Therapy		99915	0	1,585			9.02
10.00	Occupational Therapy		17140	0	0			10.00
10.01	Occupational Therapy		34620	0	7			10.01
10.02	Occupational Therapy		99915	0	227			10.02
11.00	Speech Pathology		17140	0	0			11.00
11.01	Speech Pathology		34620	0	32			11.01
11.02	Speech Pathology		99915	0	111			11.02
12.00	Medical Social Services		17140	0	0			12.00
12.01	Medical Social Services		34620	0	0			12.01
12.02	Medical Social Services		99915	0	0			12.02
13.00	Home Health Aide		17140	0	0			13.00
13.01	Home Health Aide		34620	0	4			13.01
13.02	Home Health Aide		99915	0	624			13.02
14.00	Total (sum of lines 8-13)			0	3,962			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,292		0	411,231		1.00
2.00	Physical Therapy	0	1,665		0	488,361		2.00
3.00	Occupational Therapy	0	234		0	23,208		3.00
4.00	Speech Pathology	0	143		0	25,581		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	628		0	19,342		6.00
7.00	Total (sum of lines 1-6)	0	3,962		0	967,723		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-0030 HHA CCN: 15-7430 | Period: From 01/01/2021 To 12/31/2021 | Worksheet H-3 Part I Date/Time Prepared: 5/26/2022 3:43 pm

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	1,784	0	0	0	0	15.00
16.00	Cost of Drugs	0	0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	411,231	1.00
2.00	Physical Therapy	488,361	2.00
3.00	Occupational Therapy	23,208	3.00
4.00	Speech Pathology	25,581	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	19,342	6.00
7.00	Total (sum of lines 1-6)	967,723	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
8.02	Skilled Nursing Care		8.02
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
9.02	Physical Therapy		9.02
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
10.02	Occupational Therapy		10.02
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
11.02	Speech Pathology		11.02
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
12.02	Medical Social Services		12.02
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
13.02	Home Health Aide		13.02
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0030
HHA CCN: 15-7430

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

Worksheet H-3
Part II
Date/Time Prepared:
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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.648610	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.472713	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.482605	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.126832	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.416073	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2021 To 12/31/2021 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/26/2022 3:43 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	488,708	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	43,719	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	2,904	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	13,970	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	549,301	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	549,301	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	549,301	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	549,301	29.00
30.00	OTHER	0	1	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	549,302	31.00
31.01	Sequestration adjustment (see instructions)	0	0	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)	0	0	31.75
32.00	Interim payments (see instructions)	0	549,302	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2021 To 12/31/2021 | Worksheet H-5 | Date/Time Prepared: 5/26/2022 3:43 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		549,302	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			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			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. H-4, Part II, column as appropriate, line 32)		0		549,302	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		549,302	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2021 To 12/31/2021 | Worksheet O | Date/Time Prepared: 5/26/2022 3:43 pm

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	5,722	5,722	-5,722	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	87,568	160,210	247,778	12,249	260,027	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	48,818	48,818	0	48,818	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	255	255	0	255	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	0	0	0	0	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**	26,625	0	26,625	0	26,625	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	335,417	0	335,417	0	335,417	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**	38,333	0	38,333	0	38,333	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	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**	28,317	0	28,317	0	28,317	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	516,260	215,005	731,265	6,527	737,792	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: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2021 To 12/31/2021 | Worksheet O | Date/Time Prepared: 5/26/2022 3:43 pm

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*	-15,693	244,334		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	48,818		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	255		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	0		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	26,625		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	335,417		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	38,333		33.00
34.00	SPIRITUAL COUNSELING**	0	0		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	28,317		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	-15,693	722,099		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: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2021 To 12/31/2021 | Worksheet O-2 | Date/Time Prepared: 5/26/2022 3:43 pm

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	26,306	0	26,306	0	26,306	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	331,401	0	331,401	0	331,401	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	37,874	0	37,874	0	37,874	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	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	27,978	0	27,978	0	27,978	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 *	423,559	0	423,559	0	423,559	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	26,306		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	331,401		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	37,874		33.00
34.00	SPIRITUAL COUNSELING	0	0		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	27,978		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	423,559		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: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2021 To 12/31/2021 | Worksheet O-3 | Date/Time Prepared: 5/26/2022 3:43 pm

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	84	0	84	0	84	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	1,057	0	1,057	0	1,057	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	121	0	121	0	121	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	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	89	0	89	0	89	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 *	1,351	0	1,351	0	1,351	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	84		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	1,057		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	121		33.00
34.00	SPIRITUAL COUNSELING	0	0		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	89		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	1,351		100.00

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

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

Provider CCN: 15-0030 Hospice CCN: 15-1564 | Period: From 01/01/2021 To 12/31/2021 | Worksheet O-4 | Date/Time Prepared: 5/26/2022 3:43 pm

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	235	0	235	0	235	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	2,959	0	2,959	0	2,959	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	338	0	338	0	338	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	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	250	0	250	0	250	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 *	3,782	0	3,782	0	3,782	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

		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	235		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	2,959		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	338		33.00
34.00	SPIRITUAL COUNSELING	0	0		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	250		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	3,782		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

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

Provider CCN: 15-0030 Hospice CCN: 15-1564

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

Worksheet O-5

Date/Time Prepared: 5/26/2022 3:43 pm

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	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	167,512	167,512	3.00
4.00	ADMINISTRATIVE & GENERAL	244,334	160,323	404,657	4.00
5.00	PLANT OPERATION & MAINTENANCE	48,818	63,459	112,277	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	13,570	13,570	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	255	2,083	2,338	10.00
11.00	MEDICAL RECORDS	0	1,267	1,267	11.00
12.00	STAFF TRANSPORTATION	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	0	0	0	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	423,559		423,559	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,351		1,351	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3,782		3,782	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	722,099	408,214	1,130,313	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2021 To 12/31/2021 | Worksheet O-6 Part I | Date/Time Prepared: 5/26/2022 3:43 pm

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	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	167,512	0	0	167,512		3.00
4.00	ADMINISTRATIVE & GENERAL	404,657	0	0	0	404,657	4.00
5.00	PLANT OPERATION & MAINTENANCE	112,277	0	0	0	112,277	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	13,570	0	0	0	13,570	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	2,338	0	0	0	2,338	10.00
11.00	MEDICAL RECORDS	1,267	0	0	0	1,267	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	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	423,559			165,506	589,065	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,351	0	0	528	1,879	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3,782	0	0	1,478	5,260	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	1,130,313	0	0	167,512	1,130,313	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0030 Hospice CCN: 15-1564 | Period: From 01/01/2021 To 12/31/2021 | Worksheet O-6 Part I Date/Time Prepared: 5/26/2022 3:43 pm

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	404,657					4.00
5.00	PLANT OPERATION & MAINTENANCE	62,610	174,887				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	7,567	0		21,137		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	1,304	0		0		10.00
11.00	MEDICAL RECORDS	707	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	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	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	328,488					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,048	46,051	0	5,566	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	2,933	128,836	0	15,571	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	404,657	174,887	0	21,137	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6 Part I
Date/Time Prepared: 5/26/2022 3:43 pm

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	3,642				10.00
11.00	MEDICAL RECORDS	0		1,974			11.00
12.00	STAFF TRANSPORTATION	0			0		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	3,599	1,951	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	11	6	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	32	17	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	3,642	1,974	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2021 To 12/31/2021 | Worksheet O-6 Part I | Date/Time Prepared: 5/26/2022 3:43 pm

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	0					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	0	0	0		923,103	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	54,561	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	152,649	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	0	0	0	0	1,130,313	100.00

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

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6
Part II
Date/Time Prepared:
5/26/2022 3:43 pm

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	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	167,513			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-404,657	725,656	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	112,277	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	13,570	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	2,338	10.00
11.00	MEDICAL RECORDS	0	0	0	0	1,267	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	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			165,507	0	589,065	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	528	0	1,879	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	1,478	0	5,260	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)	0	0	167,512		404,657	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.999994		0.557643	101.00

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

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6
Part II
Date/Time Prepared:
5/26/2022 3:43 pm

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	2,290					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		2,290			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	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	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	603	0	603	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,687	0	1,687	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)	174,887	0	21,137	0	0	100.00
101.00	UNIT COST MULTIPLIER	76.369869	0.000000	9.230131	0.000000	0.000000	101.00

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

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6
Part II
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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	3,174					10.00
11.00	MEDICAL RECORDS		3,174				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			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	3,136	3,136	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	10	10	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	28	28	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)	3,642	1,974	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	1.147448	0.621928	0.000000	0.000000	0.000000	101.00

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

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6 Part II
Date/Time Prepared: 5/26/2022 3:43 pm

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: 15-0030 Hospice CCN: 15-1564

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

Worksheet O-7

Date/Time Prepared: 5/26/2022 3:43 pm

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	0.648610	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.472713	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.482605	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.416073	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.175730	0	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.126832	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	CARDIAC REHAB	76.00	0.281281	0	0	0	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
6.01	BLOOD LABORATORY	0	0	0	0	0	6.01
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	CARDIAC REHAB	0	0	0	0	0	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: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2021 To 12/31/2021 | Worksheet O-8 | Date/Time Prepared: 5/26/2022 3:43 pm

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)			923,103	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			3,136	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			294.36	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	2,543	125		9.00
10.00	Program cost (line 8 times line 9)	748,557	36,795		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)			54,561	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			10	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			5,456.10	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	5	0		14.00
15.00	Program cost (line 13 times line 14)	27,281	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)			152,649	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			28	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			5,451.75	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	14	3		19.00
20.00	Program cost (line 18 times line 19)	76,325	16,355		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,130,313	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			3,174	22.00
23.00	Average cost per diem (line 21 divided by line 22)			356.12	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0030	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 5/26/2022 3:43 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	571,417	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	3,265	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	25.48	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	574,682	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0030
Component CCN: 15-8520

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

Worksheet M-1
Date/Time Prepared: 5/26/2022 3:43 pm

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	1,985,365	20,309	2,005,674	0	2,005,674	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	687,611	0	687,611	-214,056	473,555	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	458,015	300	458,315	0	458,315	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	60,989	0	60,989	0	60,989	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	468,004	0	468,004	0	468,004	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,659,984	20,609	3,680,593	-214,056	3,466,537	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	134,689	134,689	0	134,689	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	20,014	20,014	0	20,014	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	154,703	154,703	0	154,703	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,659,984	175,312	3,835,296	-214,056	3,621,240	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	636,927	636,927	0	636,927	29.00
30.00	Administrative Costs	1,093,824	1,547,246	2,641,070	-975,441	1,665,629	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,093,824	2,184,173	3,277,997	-975,441	2,302,556	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,753,808	2,359,485	7,113,293	-1,189,497	5,923,796	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0030 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1

Component CCN: 15-8520 | Date/Time Prepared: 5/26/2022 3:43 pm

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	2,005,674		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	473,555		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	458,315		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	60,989		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	468,004		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,466,537		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	134,689		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	20,014		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	154,703		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,621,240		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	-282,694	354,233		29.00
30.00	Administrative Costs	-157,453	1,508,176		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-440,147	1,862,409		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-440,147	5,483,649		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0030
Component CCN: 15-8525

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

Worksheet M-1
Date/Time Prepared: 5/26/2022 3:43 pm

RHC II | 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	3,833,657	94,003	3,927,660	0	3,927,660	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	1,942,132	0	1,942,132	228,987	2,171,119	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	377,086	0	377,086	0	377,086	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	27,068	27,068	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	1,218,599	320	1,218,919	0	1,218,919	9.00
10.00	Subtotal (sum of lines 1 through 9)	7,371,474	94,323	7,465,797	256,055	7,721,852	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	427,411	427,411	0	427,411	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	427,411	427,411	0	427,411	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	7,371,474	521,734	7,893,208	256,055	8,149,263	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	1,453,446	1,453,446	0	1,453,446	29.00
30.00	Administrative Costs	889,715	2,436,468	3,326,183	-1,522,326	1,803,857	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	889,715	3,889,914	4,779,629	-1,522,326	3,257,303	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	8,261,189	4,411,648	12,672,837	-1,266,271	11,406,566	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0030 | Component CCN: 15-8525 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/26/2022 3:43 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-1,348,024	2,579,636		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	2,171,119		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	377,086		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	27,068		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	1,218,919		9.00
10.00	Subtotal (sum of lines 1 through 9)	-1,348,024	6,373,828		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	427,411		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	427,411		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-1,348,024	6,801,239		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	-671,315	782,131		29.00
30.00	Administrative Costs	-189,078	1,614,779		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-860,393	2,396,910		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-2,208,417	9,198,149		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0030 | Component CCN: 15-8556 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/26/2022 3:43 pm

RHC III | 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	265,635	5,588	271,223	0	271,223	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	260,685	0	260,685	0	260,685	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	71,085	358	71,443	0	71,443	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	104,846	0	104,846	0	104,846	9.00
10.00	Subtotal (sum of lines 1 through 9)	702,251	5,946	708,197	0	708,197	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	32,123	32,123	0	32,123	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	32,123	32,123	0	32,123	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	702,251	38,069	740,320	0	740,320	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	215,585	215,585	0	215,585	29.00
30.00	Administrative Costs	89,401	254,555	343,956	-100,388	243,568	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	89,401	470,140	559,541	-100,388	459,153	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	791,652	508,209	1,299,861	-100,388	1,199,473	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0030 | Component CCN: 15-8556 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/26/2022 3:43 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	271,223		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	260,685		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	71,443		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	104,846		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	708,197		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	32,123		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	32,123		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	740,320		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	-86,300	129,285		29.00
30.00	Administrative Costs	-56,022	187,546		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-142,322	316,831		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-142,322	1,057,151		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0030 | Component CCN: 15-8520 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-2 | Date/Time Prepared: 5/26/2022 3:43 pm

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	4.56	14,226	1	5		1.00
2.00	Physician Assistant	1.12	1,715	1	1		2.00
3.00	Nurse Practitioner	2.85	5,054	1	3		3.00
4.00	Subtotal (sum of lines 1 through 3)	8.53	20,995		9	20,995	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	0.43	740			740	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)	8.96	21,735			21,735	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)					3,621,240	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)					3,621,240	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)					1,862,409	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					4,090,790	15.00
16.00	Total overhead (sum of lines 14 and 15)					5,953,199	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					5,953,199	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					5,953,199	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					9,574,439	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0030 | Component CCN: 15-8525 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-2 | Date/Time Prepared: 5/26/2022 3:43 pm

RHC II | 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	8.09	24,705	1	8		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	13.01	23,786	1	13		3.00
4.00	Subtotal (sum of lines 1 through 3)	21.10	48,491		21	48,491	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	0.21	230			230	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)	21.31	48,721			48,721	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)					6,801,239	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)					6,801,239	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)					2,396,910	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					7,676,922	15.00
16.00	Total overhead (sum of lines 14 and 15)					10,073,832	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					10,073,832	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					10,073,832	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					16,875,071	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0030
Component CCN: 15-8556

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

Worksheet M-2

Date/Time Prepared:
5/26/2022 3:43 pm

RHC III

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	0.60	1,082	1	1		1.00
2.00	Physician Assistant	0.17	366	1	0		2.00
3.00	Nurse Practitioner	1.61	3,216	1	2		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.38	4,664		3	4,664	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)	2.38	4,664			4,664	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)					740,320	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)					740,320	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)					316,831	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					807,564	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,124,395	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,124,395	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,124,395	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,864,715	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0030 Component CCN: 15-8520	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/26/2022 3:43 pm
	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)			9,574,439	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			205,555	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			9,368,884	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			21,735	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)			21,735	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			431.05	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	411.33	8.00
9.00	Rate for Program covered visits (see instructions)	431.05	411.33	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,426	4,550	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	614,677	1,871,552	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	2,486,229	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,087,124	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		157,394	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		359,956	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.)		1,625,725	16.04
16.05	Total program cost (see instructions)	0	1,985,681	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		94,117	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		167,123	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,985,681	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		66,906	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		2,052,587	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)		2,052,587	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		1,869,182	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)		183,405	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0030 Component CCN: 15-8525	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/26/2022 3:43 pm
	Title XVIII	RHC II	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)			16,875,071	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			1,324,614	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			15,550,457	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			48,721	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)			48,721	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			319.17	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	300.17		8.00
9.00	Rate for Program covered visits (see instructions)	319.17	300.17		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	1,694	5,282		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	540,674	1,585,498		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	2,126,172		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,446,758		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		363,057		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		533,552		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.)		1,148,522		16.04
16.05	Total program cost (see instructions)	0	1,682,074		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		156,968		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		185,317		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,682,074		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		185,036		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,867,110		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)		1,867,110		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		1,541,236		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)		325,874		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0030 Component CCN: 15-8556	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/26/2022 3:43 pm
	Title XVIII	RHC III	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)	1,864,715	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	24,802	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	1,839,913	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	4,664	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)	4,664	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	394.49	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	406.02	8.00
9.00	Rate for Program covered visits (see instructions)	394.49	394.49	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	186	710	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	73,375	280,088	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	353,463	16.00
16.01	Total program charges (see instructions)(from contractor's records)		155,800	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		34,392	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		78,025	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.)		210,353	16.04
16.05	Total program cost (see instructions)	0	288,378	16.05
17.00	Primary payer amounts		25	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		12,497	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		21,782	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		288,353	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		7,977	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		296,330	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)		296,330	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		262,902	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)		33,428	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: 15-0030 | Component CCN: 15-8520 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/26/2022 3:43 pm

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)	3,466,537	3,466,537	3,466,537	3,466,537	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000265	0.002361	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	919	8,184	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	16,758	51,884	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	17,677	60,068	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,621,240	3,621,240	3,621,240	3,621,240	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	5,953,199	5,953,199	5,953,199	5,953,199	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.004881	0.016588	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	29,058	98,752	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	46,735	158,820	0	0	10.00
11.00	Total number of injections/infusions (from your records)	98	872	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	476.89	182.13	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	41	260	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)	19,552	47,354	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)		205,555			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)		66,906			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0030 | Component CCN: 15-8525 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/26/2022 3:43 pm

Title XVIII | RHC II | 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)	6,373,828	6,373,828	6,373,828	6,373,828	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002137	0.003546	0.001529	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	13,621	22,602	9,746	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	309,339	178,560	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	322,960	201,162	9,746	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	6,801,239	6,801,239	6,801,239	6,801,239	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	10,073,832	10,073,832	10,073,832	10,073,832	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.047485	0.029577	0.001433	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	478,356	297,954	14,436	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	801,316	499,116	24,182	0	10.00
11.00	Total number of injections/infusions (from your records)	1,809	3,001	1,294	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	442.96	166.32	18.69	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	202	546	254	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)	89,478	90,811	4,747	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)		1,324,614			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)		185,036			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0030 | Component CCN: 15-8556 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/26/2022 3:43 pm

Title XVIII | RHC III | 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)	708,197	708,197	708,197	708,197	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000251	0.001324	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	178	938	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	3,078	5,653	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	3,256	6,591	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	740,320	740,320	740,320	740,320	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,124,395	1,124,395	1,124,395	1,124,395	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.004398	0.008903	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	4,945	10,010	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	8,201	16,601	0	0	10.00
11.00	Total number of injections/infusions (from your records)	18	95	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	455.61	174.75	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	6	30	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)	2,734	5,243	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)		24,802			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)		7,977			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0030 Component CCN: 15-8520	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/26/2022 3:43 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,338,082	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	531,100	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)		531,100	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,869,182	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		183,405	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		2,052,587	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0030 Component CCN: 15-8525	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/26/2022 3:43 pm

			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			1,347,736	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	193,500	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)			193,500	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			1,541,236	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			325,874	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			1,867,110	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0030 | Component CCN: 15-8556 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-5 | Date/Time Prepared: 5/26/2022 3:43 pm

RHC III | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		81,302	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	181,600	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)		181,600	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		262,902	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		33,428	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		296,330	7.00

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