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: 15-1306	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/26/2022 1:16 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/26/2022 Time: 1:16 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 IU HEALTH PAOLI HOSPITAL (15-1306) 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	Michael Craig		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	Michael Craig			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			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	-386,908	-1,289,886	0	0	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	-17,286	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		31,226		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	-404,194	-1,258,660	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 1:16 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 642 WEST HOSPITAL ROAD	PO Box:			1.00
2.00	City: PAOLI	State: IN	Zip Code: 47454	County: ORANGE	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	IU HEALTH PAOLI HOSPITAL	151306	99915	1	07/01/2001	N	O	P	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	IUHP SWING BEDS	15Z306	99915		07/01/2001	N	O	N	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									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	IU HEALTH PAOLI FAMILY AND INTERNAL	158557	99915		12/07/2020	N	O	O	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				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: 15-1306	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 1:16 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

		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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 1:16 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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.	N	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.	N	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.	N	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.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
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.	Y		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

Line	Description	1.00	2.00	Line
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

Line	Description	1.00	2.00	3.00	Line
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

Line	Description	Premiums 1.00	Losses 2.00	Insurance 3.00	Line
118.01	List amounts of malpractice premiums and paid losses:	37,791	0	0	118.01

Line	Description	1.00	2.00	Line
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.	Y		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
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	15H059	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 1:16 pm

	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: INDIANA UNIVERSITY HEALTH	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST TENTH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46204	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)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		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)	Y	51	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2022 1:16 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)	Y			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	02/25/2022	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)	N		N		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)	Y	04/01/2022	Y	04/01/2022	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: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 1:16 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.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	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.	RHONDA	UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093	RUTTER@IUHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1306	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 1:16 pm

		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: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 1:16 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	24	8,760	36,360.00	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)		24	8,760	36,360.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	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)		24	8,760	36,360.00	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						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				35	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		24				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: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 1:16 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)	614	36	1,515			1.00
2.00	HMO and other (see instructions)	338	323				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	64	0	64			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	71			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	678	36	1,650			7.00
8.00	INTENSIVE CARE UNIT	0	0	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		12	156			13.00
14.00	Total (see instructions)	678	48	1,806	0.00	135.22	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			31			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	651	0	7,150	0.00	3.50	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	138.72	27.00
28.00	Observation Bed Days		5	474			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 1:16 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	174	9	430	1.00
2.00	HMO and other (see instructions)			76	129		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	174	9	430	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						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1306 | Component CCN: 15-8557 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/26/2022 1:16 pm

RHC I | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street		1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County				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						11.00

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

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

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

		County	
		4.00	
2.00	City, State, ZIP Code, County		2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8

Component CCN: 15-8557 | Date/Time Prepared: 5/26/2022 1:16 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						11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-10 | Date/Time Prepared: 5/26/2022 1:16 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)	0.339220	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,249,275	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	22,267,577	6.00
7.00	Medicaid cost (line 1 times line 6)	7,553,607	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)	304,332	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)	6,530	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	51,582	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	17,498	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)	10,968	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)	315,300	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)	1,491,148	256,978	1,748,126	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	505,827	256,978	762,805	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)	505,827	256,978	762,805	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)	2,850,333	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	612,437	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	942,211	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,908,122	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	977,047	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,739,852	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,055,152	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/26/2022 1:16 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	CAP REL COSTS-BLDG & FIXT		0	0	571,488	571,488	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	911,663	911,663	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	83,139	83,139	1,933,779	2,016,918	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	499,015	5,799,011	6,298,026	-40,441	6,257,585	5.00
7.00	00700	OPERATION OF PLANT	431,205	1,551,087	1,982,292	-752,399	1,229,893	7.00
7.01	00701	UTILITIES	0	0	0	371,388	371,388	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	2	2	71,587	71,589	8.00
9.00	00900	HOUSEKEEPING	237,043	352,979	590,022	-147,109	442,913	9.00
10.00	01000	DIETARY	167,532	322,703	490,235	-239,897	250,338	10.00
11.00	01100	CAFETERIA	0	0	0	178,872	178,872	11.00
13.00	01300	NURSING ADMINISTRATION	1,363,548	503,659	1,867,207	-650,821	1,216,386	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	41,342	41,342	195,451	236,793	14.00
15.00	01500	PHARMACY	260,375	2,218,637	2,479,012	-2,038,120	440,892	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	391,317	299,698	691,015	-79,660	611,355	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,377,723	1,707,910	3,085,633	-471,528	2,614,105	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	145,340	17,518	162,858	-117,136	45,722	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	469,887	511,200	981,087	-364,132	616,955	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,596	985	34,581	163,824	198,405	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	921,314	944,857	1,866,171	-465,493	1,400,678	54.00
60.00	06000	LABORATORY	0	1,886,691	1,886,691	1,869	1,888,560	60.00
64.00	06400	INTRAVENOUS THERAPY	122,558	68,139	190,697	-35,573	155,124	64.00
65.00	06500	RESPIRATORY THERAPY	293,368	182,076	475,444	-48,573	426,871	65.00
66.00	06600	PHYSICAL THERAPY	570,826	420,234	991,060	-438,860	552,200	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	116,294	116,294	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	77,985	77,985	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	75,139	75,139	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	28,613	28,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,077,598	2,077,598	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,180,045	639,743	1,819,788	-414,614	1,405,174	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	42,379	29,944	72,323	-226	72,097	90.00
90.01	09001	VISITING SPECIALTY CLINIC	182,857	141,521	324,378	-85,135	239,243	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	1,407,740	1,868,215	3,275,955	-384,197	2,891,758	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,097,668	19,591,290	29,688,958	1,636	29,690,594	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	203	203	0	203	190.01
190.02	19002	OUTREACH	0	0	0	2	2	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	4,536	4,536	-264	4,272	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,393	1,393	-1,374	19	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	10,097,668	19,597,422	29,695,090	0	29,695,090	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/26/2022 1:16 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	571,488	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	911,663	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-13,081	2,003,837	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,072,331	7,329,916	5.00
7.00	00700	OPERATION OF PLANT	0	1,229,893	7.00
7.01	00701	UTILITIES	0	371,388	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	71,589	8.00
9.00	00900	HOUSEKEEPING	0	442,913	9.00
10.00	01000	DIETARY	0	250,338	10.00
11.00	01100	CAFETERIA	-29,258	149,614	11.00
13.00	01300	NURSING ADMINISTRATION	4,913	1,221,299	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	236,793	14.00
15.00	01500	PHARMACY	72,144	513,036	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-357,533	253,822	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-909,141	1,704,964	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	0	45,722	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	225	617,180	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	198,405	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,983	1,426,661	54.00
60.00	06000	LABORATORY	25,000	1,913,560	60.00
64.00	06400	INTRAVENOUS THERAPY	0	155,124	64.00
65.00	06500	RESPIRATORY THERAPY	0	426,871	65.00
66.00	06600	PHYSICAL THERAPY	65,534	617,734	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	116,294	67.00
68.00	06800	SPEECH PATHOLOGY	0	77,985	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	75,139	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	28,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,077,598	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	-27,280	1,377,894	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-12,210	59,887	90.00
90.01	09001	VISITING SPECIALTY CLINIC	-220	239,023	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	90.02
91.00	09100	EMERGENCY	-238,267	2,653,491	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-320,860	29,369,734	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	203	190.01
190.02	19002	OUTREACH	0	2	190.02
190.03	19003	FOUNDATION	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	4,272	190.05
190.06	19006	OTHER PROPERTY	0	0	190.06
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	19	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-320,860	29,374,230	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,882,889	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	0		0	1,882,889	
	B - BILLABLE DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,077,598	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	2,077,598	
	C - BILLABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		75,139	1.00
2.00	CLINIC	90.00		1,575	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	0		0	76,714	
	D - IMPLANT SUPPLIES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		28,613	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	28,613	
	E - NON-BILLABLE DRUGS				
1.00	PHARMACY	15.00	0	86,800	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	343	2.00
3.00	RURAL HEALTH CLINIC	88.00	0	320	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	87,463	
	F - NON-BILLABLE MED SUPPLIES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	203,901	1.00
2.00	OPERATION OF PLANT	7.00	0	5	2.00
3.00	HOUSEKEEPING	9.00	0	368	3.00
4.00	DIETARY	10.00	0	20	4.00
5.00	NURSING ADMINISTRATION	13.00	0	626	5.00
6.00	OPERATING ROOM	50.00	0	331	6.00
7.00	PHYSICAL THERAPY	66.00	0	119	7.00
8.00	OUTREACH	190.02	0	2	8.00
9.00		0.00	0	0	9.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	0		0	205,372	
	G - CAPITAL RELATED COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	457,978	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	911,663	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	0		0	1,369,641	
	H - LEASE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	113,510	1.00
	0		0	113,510	
	I - COO/CNO				
1.00	ADMINISTRATIVE & GENERAL	5.00	191,485	0	1.00
	0		191,485	0	
	J - UTILITIES				
1.00	UTILITIES	7.01	0	371,388	1.00
2.00		0.00	0	0	2.00
	0		0	371,388	
	K - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	71,587	1.00
	TOTALS		0	71,587	
	L - OBSTETRICS				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	124,310	39,563	1.00
2.00		0.00	0	0	2.00
	0		124,310	39,563	
	M - CAFETERIA				
1.00	CAFETERIA	11.00	67,908	110,964	1.00
	0		67,908	110,964	
	N - OT AND ST				
1.00	OCCUPATIONAL THERAPY	67.00	90,612	25,682	1.00
2.00	SPEECH PATHOLOGY	68.00	60,763	17,222	2.00
	0		151,375	42,904	
	O - ACCRUED PTO				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	51,693	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	681	0	2.00
3.00	OPERATION OF PLANT	7.00	7,054	0	3.00
4.00	NURSING ADMINISTRATION	13.00	5,323	0	4.00
5.00	PHARMACY	15.00	6,115	0	5.00
6.00	RESPIRATORY THERAPY	65.00	3,542	0	6.00
7.00	PHYSICAL THERAPY	66.00	10,802	0	7.00
8.00	RURAL HEALTH CLINIC	88.00	6,482	0	8.00
9.00	EMERGENCY	91.00	10,108	0	9.00
	TOTALS		101,800	0	
	Q - BLOOD STORAGE				
1.00	LABORATORY	60.00	0	4,504	1.00
	TOTALS		0	4,504	
	R - PREMIUM WAGES				
1.00	ADULTS & PEDIATRICS	30.00	67,271	4,945	1.00
2.00	OPERATING ROOM	50.00	33,039	2,429	2.00
3.00	RESPIRATORY THERAPY	65.00	44,912	3,302	3.00
4.00	EMERGENCY	91.00	71,541	5,259	4.00
	TOTALS		216,763	15,935	
500.00	Grand Total: Increases		853,641	6,498,645	500.00

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00		60,337	0	1.00
2.00	OPERATION OF PLANT	7.00		103,503	0	2.00
3.00	HOUSEKEEPING	9.00		68,514	0	3.00
4.00	DIETARY	10.00		50,369	0	4.00
5.00	NURSING ADMINISTRATION	13.00		221,812	0	5.00
6.00	PHARMACY	15.00		48,633	0	6.00
7.00	NONPHYSICIAN ANESTHETISTS	19.00		28,818	0	7.00
8.00	ADULTS & PEDIATRICS	30.00		330,632	0	8.00
9.00	OPERATING ROOM	50.00		98,524	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00		127,997	0	10.00
11.00	INTRAVENOUS THERAPY	64.00		23,522	0	11.00
12.00	RESPIRATORY THERAPY	65.00		35,715	0	12.00
13.00	PHYSICAL THERAPY	66.00		108,596	0	13.00
14.00	RURAL HEALTH CLINIC	88.00		216,671	0	14.00
15.00	CLINIC	90.00		1,801	0	15.00
16.00	VISITING SPECIALTY CLINIC	90.01		56,515	0	16.00
17.00	EMERGENCY	91.00		299,556	0	17.00
18.00	PHYSICIANS' PRIVATE OFFICES	192.00		1,374	0	18.00
	0		0	1,882,889		
	B - BILLABLE DRUGS					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	375	0	1.00
2.00	PHARMACY	15.00	0	2,007,554	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	5,420	0	3.00
4.00	NURSERY	43.00	0	438	0	4.00
5.00	OPERATING ROOM	50.00	0	3,088	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	44,834	0	6.00
7.00	INTRAVENOUS THERAPY	64.00	0	1,801	0	7.00
8.00	RESPIRATORY THERAPY	65.00	0	953	0	8.00
9.00	PHYSICAL THERAPY	66.00	0	80	0	9.00
10.00	VISITING SPECIALTY CLINIC	90.01	0	3,558	0	10.00
11.00	EMERGENCY	91.00	0	9,497	0	11.00
	0		0	2,077,598		
	C - BILLABLE SUPPLIES					
1.00	HOUSEKEEPING	9.00		33	0	1.00
2.00	NURSING ADMINISTRATION	13.00		708	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00		7,153	0	3.00
4.00	PHARMACY	15.00		42	0	4.00
5.00	ADULTS & PEDIATRICS	30.00		7,639	0	5.00
6.00	NURSERY	43.00		946	0	6.00
7.00	OPERATING ROOM	50.00		40,178	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00		1,013	0	8.00
9.00	INTRAVENOUS THERAPY	64.00		782	0	9.00
10.00	RESPIRATORY THERAPY	65.00		417	0	10.00
11.00	PHYSICAL THERAPY	66.00		4,589	0	11.00
12.00	VISITING SPECIALTY CLINIC	90.01		4,986	0	12.00
13.00	EMERGENCY	91.00		8,228	0	13.00
	0		0	76,714		
	D - IMPLANT SUPPLIES					
1.00	NURSING ADMINISTRATION	13.00		5,025	0	1.00
2.00	OPERATING ROOM	50.00		22,679	0	2.00
3.00	EMERGENCY	91.00		909	0	3.00
	0		0	28,613		
	E - NON-BILLABLE DRUGS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	358	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	14,996	0	2.00
3.00	NURSERY	43.00	0	672	0	3.00
4.00	OPERATING ROOM	50.00	0	4,822	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,240	0	5.00
6.00	INTRAVENOUS THERAPY	64.00	0	6,116	0	6.00
7.00	EMERGENCY	91.00	0	53,259	0	7.00
	0		0	87,463		
	F - NON-BILLABLE MED SUPPLIES					
1.00	ADMINISTRATIVE & GENERAL	5.00		2,564	0	1.00
2.00	PHARMACY	15.00		5,386	0	2.00
3.00	NONPHYSICIAN ANESTHETISTS	19.00		1,651	0	3.00
4.00	ADULTS & PEDIATRICS	30.00		45,180	0	4.00
5.00	NURSERY	43.00		4,640	0	5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00		49	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00		17,427	0	7.00
8.00	LABORATORY	60.00		2,635	0	8.00
9.00	INTRAVENOUS THERAPY	64.00		2,640	0	9.00
10.00	RESPIRATORY THERAPY	65.00		56,038	0	10.00
11.00	RURAL HEALTH CLINIC	88.00		1,166	0	11.00

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
12.00	VISITING SPECIALTY CLINIC	90.01		5,929	0	12.00
13.00	EMERGENCY	91.00		60,067	0	13.00
	0		0	205,372		
	G - CAPITAL RELATED COSTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		803	9	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00		56,196	9	2.00
3.00	OPERATION OF PLANT	7.00		325,755	0	3.00
4.00	HOUSEKEEPING	9.00		948	0	4.00
5.00	DIETARY	10.00		6,091	0	5.00
6.00	NURSING ADMINISTRATION	13.00		5,042	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00		1,265	0	7.00
8.00	PHARMACY	15.00		69,420	0	8.00
9.00	NONPHYSICIAN ANESTHETISTS	19.00		7,854	0	9.00
10.00	ADULTS & PEDIATRICS	30.00		66,143	0	10.00
11.00	NURSERY	43.00		597	0	11.00
12.00	OPERATING ROOM	50.00		213,609	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00		264,422	0	13.00
14.00	RESPIRATORY THERAPY	65.00		7,206	0	14.00
15.00	PHYSICAL THERAPY	66.00		142,237	0	15.00
16.00	RURAL HEALTH CLINIC	88.00		157,887	0	16.00
17.00	VISITING SPECIALTY CLINIC	90.01		4,313	0	17.00
18.00	EMERGENCY	91.00		39,589	0	18.00
19.00	PAOLI FAMILY PRACTICE	190.05		264	0	19.00
	0		0	1,369,641		
	H - LEASE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	113,510	10	1.00
	0		0	113,510		
	I - COO/CNO					
1.00	NURSING ADMINISTRATION	13.00	191,485	0	0	1.00
	0		191,485	0		
	J - UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	325,696	0	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	45,692	0	2.00
	0		0	371,388		
	K - LAUNDRY					
1.00	HOUSEKEEPING	9.00	0	71,587	0	1.00
	TOTALS		0	71,587		
	L - OBSTETRICS					
1.00	ADULTS & PEDIATRICS	30.00	15,360	38,670	0	1.00
2.00	NURSERY	43.00	108,950	893	0	2.00
	0		124,310	39,563		
	M - CAFETERIA					
1.00	DIETARY	10.00	67,908	110,964	0	1.00
	0		67,908	110,964		
	N - OT AND ST					
1.00	PHYSICAL THERAPY	66.00	151,375	42,904	0	1.00
2.00		0.00	0	0	0	2.00
	0		151,375	42,904		
	O - ACCRUED PTO					
1.00	HOUSEKEEPING	9.00	6,395	0	0	1.00
2.00	DIETARY	10.00	4,585	0	0	2.00
3.00	NONPHYSICIAN ANESTHETISTS	19.00	40,979	0	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	19,704	0	0	4.00
5.00	OPERATING ROOM	50.00	17,031	0	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	2,560	0	0	6.00
7.00	INTRAVENOUS THERAPY	64.00	712	0	0	7.00
8.00	VISITING SPECIALTY CLINIC	90.01	9,834	0	0	8.00
9.00		0.00	0	0	0	9.00
	TOTALS		101,800	0		
	Q - BLOOD STORAGE					
1.00	OPERATION OF PLANT	7.00	0	4,504	0	1.00
	TOTALS		0	4,504		
	R - PREMIUM WAGES					
1.00	NURSING ADMINISTRATION	13.00	216,763	15,935	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
	TOTALS		216,763	15,935		
500.00	Grand Total: Decreases		853,641	6,498,645		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2022 1:16 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	183,505	0	0	0	0	1.00
2.00	Land Improvements	438,464	187,140	0	187,140	0	2.00
3.00	Buildings and Fixtures	4,741,722	3,789,830	0	3,789,830	0	3.00
4.00	Building Improvements	1,939,739	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	11,151,354	1,056,677	0	1,056,677	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,454,784	5,033,647	0	5,033,647	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	18,454,784	5,033,647	0	5,033,647	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	183,505	0	1.00
2.00	Land Improvements	625,604	258,464	2.00
3.00	Buildings and Fixtures	8,531,552	2,449,205	3.00
4.00	Building Improvements	1,939,739	791,602	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	12,208,031	4,019,110	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	23,488,431	7,518,381	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	23,488,431	7,518,381	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II | Date/Time Prepared: 5/26/2022 1:16 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	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	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	CAP REL COSTS-BLDG & FIXT	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III | Date/Time Prepared: 5/26/2022 1:16 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	CAP REL COSTS-BLDG & FIXT	11,280,400	0	11,280,400	0.480253	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,208,031	0	12,208,031	0.519747	0	2.00
3.00	Total (sum of lines 1-2)	23,488,431	0	23,488,431	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	CAP REL COSTS-BLDG & FIXT	0	0	0	445,935	125,553	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	911,663	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,357,598	125,553	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	CAP REL COSTS-BLDG & FIXT	0	0	0	0	571,488	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	911,663	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,483,151	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/26/2022 1:16 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 - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	12,043	CAP REL COSTS-BLDG & FIXT	1.00	10	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	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)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,917,608			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	5,562,259			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-29,258	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		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	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	4,594	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/26/2022 1:16 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS INCOME	B	-13,842	PHARMACY	15.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	225	OPERATING ROOM	50.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-600	PHYSICAL THERAPY	66.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-4,508	RURAL HEALTH CLINIC	88.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-220	VISITING SPECIALTY CLINIC	90.01	0	33.05
33.06	HAF	B	-758,889	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	BENEFITS	A	-1,882,438	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	CRNA	A	-357,533	NONPHYSICIAN ANESTHETISTS	19.00	0	33.08
33.09	MARKETING	A	-252	RURAL HEALTH CLINIC	88.00	0	33.09
33.10	CLINIC START UP AMORTIZIATION	A	41,430	RURAL HEALTH CLINIC	88.00	0	33.10
33.11	UNWONTED SITUATIONS	A	-1,250	NURSING ADMINISTRATION	13.00	0	33.11
33.12	TELEPHONE EXPENSE	A	-13	RURAL HEALTH CLINIC	88.00	0	33.12
33.13	MEDICAL DIRECTOR FEE	A	25,000	LABORATORY	60.00	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-320,860				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: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2022 1:16 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	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	-12,043	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1,819,379	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4,931,869	4,194,234	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	250,489	0	3.01
3.02	88.00	RURAL HEALTH CLINIC	HOME OFFICE ALLOCATION	0	63,937	3.02
3.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	90,210	40,232	3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	1,256,450	398,633	3.04
3.05	13.00	NURSING ADMINISTRATION	RELATED PARTY	36,789	29,379	3.05
3.06	15.00	PHARMACY	RELATED PARTY	191,912	105,926	3.06
3.07	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY	25,983	0	3.07
3.08	66.00	PHYSICAL THERAPY	RELATED PARTY	163,592	97,458	3.08
3.09	90.00	CLINIC	RELATED PARTY	13,243	25,453	3.09
3.10	91.00	EMERGENCY	SIP ER ALLOCATION	2,806,323	1,056,685	3.10
3.11	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	2,463	2,463	3.11
3.12	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	26,088	26,088	3.12
3.13	10.00	DIETARY	SHARED EMPLOYEES	5,723	5,723	3.13
3.14	15.00	PHARMACY	SHARED EMPLOYEES	-27,173	-27,173	3.14
3.15	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	38,916	38,916	3.15
3.16	60.00	LABORATORY	SHARED EMPLOYEES	1,853,780	1,853,780	3.16
3.17	65.00	RESPIRATORY THERAPY	SHARED EMPLOYEES	7,875	7,875	3.17
3.18	66.00	PHYSICAL THERAPY	SHARED EMPLOYEES	-26,866	-26,866	3.18
3.19	88.00	RURAL HEALTH CLINIC	SHARED EMPLOYEES	3,745	3,745	3.19
4.00	91.00	EMERGENCY	SHARED EMPLOYEES	-23,446	-23,446	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			13,435,301	7,873,042	5.00

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	IU HEALTH BLOOM	0.00	6.00
7.00	B		0.00	IU HEALTH	100.00	7.00
8.00	C		0.00	IUH SIP	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:					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: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2022 1:16 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	-12,043	9	1.00
2.00	1,819,379	9	2.00
3.00	737,635	0	3.00
3.01	250,489	0	3.01
3.02	-63,937	9	3.02
3.03	49,978	0	3.03
3.04	857,817	0	3.04
3.05	7,410	0	3.05
3.06	85,986	0	3.06
3.07	25,983	0	3.07
3.08	66,134	0	3.08
3.09	-12,210	0	3.09
3.10	1,749,638	0	3.10
3.11	0	0	3.11
3.12	0	0	3.12
3.13	0	0	3.13
3.14	0	0	3.14
3.15	0	0	3.15
3.16	0	0	3.16
3.17	0	0	3.17
3.18	0	0	3.18
3.19	0	0	3.19
4.00	0	0	4.00
5.00	5,562,259		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	HOSPITAL	6.00
7.00	HOME OFFICE	7.00
8.00	PHYSICIAN GROUP	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: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2022 1:16 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	5.00	ADMINISTRATIVE & GENERAL	19,315	19,315	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	1,247	1,247	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	909,141	909,141	0	0	0	3.00
4.00	91.00	EMERGENCY	2,578,847	1,987,905	590,942	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	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			3,508,550	2,917,608	590,942		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	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			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	19,315		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	1,247		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	909,141		3.00
4.00	91.00	EMERGENCY	0	0	0	1,987,905		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		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	0	0	2,917,608		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 1:16 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	571,488	571,488				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	911,663		911,663			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,003,837	6,740	11,347	2,021,924		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,329,916	32,884	55,363	139,112	7,557,275	5.00
7.00	00700	OPERATION OF PLANT	1,229,893	40,295	67,839	88,207	1,426,234	7.00
7.01	00701	UTILITIES	371,388	0	0	0	371,388	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	71,589	2,718	4,575	0	78,882	8.00
9.00	00900	HOUSEKEEPING	442,913	8,026	13,513	46,422	510,874	9.00
10.00	01000	DIETARY	250,338	16,116	27,133	19,128	312,715	10.00
11.00	01100	CAFETERIA	149,614	8,851	14,901	13,668	187,034	11.00
13.00	01300	NURSING ADMINISTRATION	1,221,299	16,977	28,581	193,342	1,460,199	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	236,793	18,671	31,434	0	286,898	14.00
15.00	01500	PHARMACY	513,036	10,590	17,829	53,636	595,091	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,821	11,484	0	18,305	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	253,822	0	0	70,511	324,333	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,704,964	67,681	113,944	283,772	2,170,361	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	45,722	2,265	3,813	7,324	59,124	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	617,180	54,599	91,921	97,795	861,495	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	198,405	4,539	7,641	31,781	242,366	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,426,661	54,227	91,296	184,915	1,757,099	54.00
60.00	06000	LABORATORY	1,913,560	17,248	29,039	0	1,959,847	60.00
64.00	06400	INTRAVENOUS THERAPY	155,124	6,957	11,713	24,524	198,318	64.00
65.00	06500	RESPIRATORY THERAPY	426,871	4,412	7,428	68,797	507,508	65.00
66.00	06600	PHYSICAL THERAPY	617,734	37,477	63,096	86,596	804,903	66.00
67.00	06700	OCCUPATIONAL THERAPY	116,294	7,890	13,284	18,237	155,705	67.00
68.00	06800	SPEECH PATHOLOGY	77,985	5,290	8,907	12,230	104,412	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	75,139	0	0	0	75,139	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,613	0	0	0	28,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,077,598	0	0	0	2,077,598	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,377,894	45,277	75,770	238,809	1,737,750	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	59,887	344	580	8,529	69,340	90.00
90.01	09001	VISITING SPECIALTY CLINIC	239,023	27,530	46,350	34,824	347,727	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	2,653,491	37,350	62,882	299,765	3,053,488	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,369,734	541,775	911,663	2,021,924	29,340,021	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	203	0	0	0	203	190.01
190.02	19002	OUTREACH	2	4,058	0	0	4,060	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	4,272	0	0	0	4,272	190.05
190.06	19006	OTHER PROPERTY	0	25,655	0	0	25,655	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19	0	0	0	19	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	29,374,230	571,488	911,663	2,021,924	29,374,230	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/26/2022 1:16 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	UTILITIES	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,557,275					5.00
7.00	00700	OPERATION OF PLANT	494,040	1,920,274				7.00
7.01	00701	UTILITIES	128,647	0	500,035			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	27,324	12,835	2,789	121,830		8.00
9.00	00900	HOUSEKEEPING	176,964	37,905	8,237	0	733,980	9.00
10.00	01000	DIETARY	108,323	76,109	16,539	0	27,791	10.00
11.00	01100	CAFETERIA	64,788	41,798	9,083	0	15,262	11.00
13.00	01300	NURSING ADMINISTRATION	505,806	51,296	17,422	0	29,275	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	99,380	88,174	19,161	0	0	14.00
15.00	01500	PHARMACY	206,137	50,012	10,868	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,341	32,215	7,001	0	11,763	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	112,347	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	751,802	319,623	69,459	110,456	116,711	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	20,480	10,696	2,324	11,374	3,905	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	298,418	257,848	56,033	0	94,151	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	83,954	21,434	4,658	0	7,826	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	608,650	256,094	55,651	0	93,511	54.00
60.00	06000	LABORATORY	678,881	81,457	17,701	0	29,743	60.00
64.00	06400	INTRAVENOUS THERAPY	68,696	32,857	7,140	0	11,997	64.00
65.00	06500	RESPIRATORY THERAPY	175,798	20,835	4,528	0	7,608	65.00
66.00	06600	PHYSICAL THERAPY	278,814	6,289	38,461	0	64,626	66.00
67.00	06700	OCCUPATIONAL THERAPY	53,935	1,326	8,098	0	13,606	67.00
68.00	06800	SPEECH PATHOLOGY	36,168	898	5,429	0	9,123	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,028	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,911	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	719,670	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	601,948	212,541	46,187	0	77,608	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	24,019	1,626	353	0	594	90.00
90.01	09001	VISITING SPECIALTY CLINIC	120,451	130,015	28,253	0	47,474	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	1,057,705	176,391	38,331	0	64,408	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,545,425	1,920,274	473,706	121,830	726,982	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	70	0	0	0	0	190.01
190.02	19002	OUTREACH	1,406	0	0	0	6,998	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	1,480	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	8,887	0	26,329	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	7,557,275	1,920,274	500,035	121,830	733,980	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/26/2022 1:16 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	541,477					10.00
11.00	01100	CAFETERIA	0	317,965				11.00
13.00	01300	NURSING ADMINISTRATION	0	30,012	2,094,010			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	493,613		14.00
15.00	01500	PHARMACY	0	10,471	0	8,334	880,913	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	5,651	0	2,806	146	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	541,477	50,543	856,865	66,182	6,102	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	1,137	20,054	8,003	273	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,468	205,847	39,954	1,962	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,933	87,036	70	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,847	42,317	27,130	2,946	54.00
60.00	06000	LABORATORY	0	32,555	0	3,872	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	3,902	68,832	4,056	2,488	64.00
65.00	06500	RESPIRATORY THERAPY	0	9,753	0	80,402	0	65.00
66.00	06600	PHYSICAL THERAPY	0	16,781	0	804	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,418	0	170	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,450	0	114	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	107,249	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	40,838	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	845,326	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	34,219	166,003	6,163	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	892	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	10,553	41,116	9,422	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	51,380	605,940	88,044	21,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	541,477	317,965	2,094,010	493,613	880,913	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	0	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	541,477	317,965	2,094,010	493,613	880,913	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 1:16 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
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	75,625					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	445,283			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,703	0	0	5,065,284	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	223	0	0	137,593	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,717	0	445,283	2,281,176	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	837	0	0	453,114	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,559	0	0	2,891,804	0	54.00
60.00	06000	LABORATORY	7,051	0	0	2,811,107	0	60.00
64.00	06400	INTRAVENOUS THERAPY	2,142	0	0	400,428	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,599	0	0	808,031	0	65.00
66.00	06600	PHYSICAL THERAPY	1,682	0	0	1,212,360	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	325	0	0	236,583	0	67.00
68.00	06800	SPEECH PATHOLOGY	180	0	0	158,774	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	162	0	0	208,578	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46	0	0	79,408	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,369	0	0	3,654,963	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,109	0	0	2,883,528	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	64	0	0	96,888	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	872	0	0	735,883	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	21,985	0	0	5,179,342	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,625	0	445,283	29,294,844	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	273	0	190.01
190.02	19002	OUTREACH	0	0	0	12,464	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	5,752	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	60,871	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	26	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	75,625	0	445,283	29,374,230	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 1:16 pm

		Cost Center Description	Total	
			26.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	UTILITIES		7.01
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	5,065,284	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	137,593	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	2,281,176	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	453,114	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,891,804	54.00
60.00	06000	LABORATORY	2,811,107	60.00
64.00	06400	INTRAVENOUS THERAPY	400,428	64.00
65.00	06500	RESPIRATORY THERAPY	808,031	65.00
66.00	06600	PHYSICAL THERAPY	1,212,360	66.00
67.00	06700	OCCUPATIONAL THERAPY	236,583	67.00
68.00	06800	SPEECH PATHOLOGY	158,774	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	208,578	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	79,408	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,654,963	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	2,883,528	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	96,888	90.00
90.01	09001	VISITING SPECIALTY CLINIC	735,883	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	90.02
91.00	09100	EMERGENCY	5,179,342	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,294,844	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	273	190.01
190.02	19002	OUTREACH	12,464	190.02
190.03	19003	FOUNDATION	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	5,752	190.05
190.06	19006	OTHER PROPERTY	60,871	190.06
191.00	19100	RESEARCH	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26	192.00
193.00	19300	NONPAID WORKERS	0	193.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	29,374,230	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 1:16 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,740	11,347	18,087	18,087	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	250,489	32,884	55,363	338,736	1,244	5.00
7.00	00700	OPERATION OF PLANT	0	40,295	67,839	108,134	789	7.00
7.01	00701	UTILITIES	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,718	4,575	7,293	0	8.00
9.00	00900	HOUSEKEEPING	0	8,026	13,513	21,539	415	9.00
10.00	01000	DIETARY	0	16,116	27,133	43,249	171	10.00
11.00	01100	CAFETERIA	0	8,851	14,901	23,752	122	11.00
13.00	01300	NURSING ADMINISTRATION	0	16,977	28,581	45,558	1,729	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18,671	31,434	50,105	0	14.00
15.00	01500	PHARMACY	0	10,590	17,829	28,419	480	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,821	11,484	18,305	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	631	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	67,681	113,944	181,625	2,538	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	2,265	3,813	6,078	66	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	54,599	91,921	146,520	875	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,539	7,641	12,180	284	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,227	91,296	145,523	1,654	54.00
60.00	06000	LABORATORY	0	17,248	29,039	46,287	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	6,957	11,713	18,670	219	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,412	7,428	11,840	615	65.00
66.00	06600	PHYSICAL THERAPY	0	37,477	63,096	100,573	774	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,890	13,284	21,174	163	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,290	8,907	14,197	109	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	45,277	75,770	121,047	2,136	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	344	580	924	76	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	27,530	46,350	73,880	311	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	37,350	62,882	100,232	2,686	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	250,489	541,775	911,663	1,703,927	18,087	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	4,058	0	4,058	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	25,655	0	25,655	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	250,489	571,488	911,663	1,733,640	18,087	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 1:16 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	UTILITIES	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	339,980					5.00
7.00	00700	OPERATION OF PLANT	22,225	131,148				7.00
7.01	00701	UTILITIES	5,787	0	5,787			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,229	877	32	9,431		8.00
9.00	00900	HOUSEKEEPING	7,961	2,589	95	0	32,599	9.00
10.00	01000	DIETARY	4,873	5,198	191	0	1,234	10.00
11.00	01100	CAFETERIA	2,915	2,855	105	0	678	11.00
13.00	01300	NURSING ADMINISTRATION	22,754	3,503	202	0	1,300	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,471	6,022	222	0	0	14.00
15.00	01500	PHARMACY	9,273	3,416	126	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	285	2,200	81	0	522	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	5,054	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,821	21,828	803	8,551	5,184	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	921	730	27	880	173	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,425	17,610	648	0	4,182	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,777	1,464	54	0	348	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,381	17,490	644	0	4,153	54.00
60.00	06000	LABORATORY	30,540	5,563	205	0	1,321	60.00
64.00	06400	INTRAVENOUS THERAPY	3,090	2,244	83	0	533	64.00
65.00	06500	RESPIRATORY THERAPY	7,908	1,423	52	0	338	65.00
66.00	06600	PHYSICAL THERAPY	12,543	430	445	0	2,870	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,426	91	94	0	604	67.00
68.00	06800	SPEECH PATHOLOGY	1,627	61	63	0	405	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,171	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	446	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,375	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	27,079	14,516	535	0	3,447	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,081	111	4	0	26	90.00
90.01	09001	VISITING SPECIALTY CLINIC	5,419	8,880	327	0	2,109	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	47,590	12,047	444	0	2,861	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	339,447	131,148	5,482	9,431	32,288	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	3	0	0	0	0	190.01
190.02	19002	OUTREACH	63	0	0	0	311	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	67	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	400	0	305	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	339,980	131,148	5,787	9,431	32,599	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/26/2022 1:16 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	54,916					10.00
11.00	01100	CAFETERIA	0	30,427				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,872	77,918			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	60,820		14.00
15.00	01500	PHARMACY	0	1,002	0	1,027	43,743	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	541	0	346	7	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,916	4,837	31,883	8,155	303	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	109	746	986	14	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,384	7,660	4,923	97	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	472	3,239	9	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,335	1,575	3,343	146	54.00
60.00	06000	LABORATORY	0	3,115	0	477	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	373	2,561	500	124	64.00
65.00	06500	RESPIRATORY THERAPY	0	933	0	9,907	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,606	0	99	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	327	0	21	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	234	0	14	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	13,213	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,032	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	41,976	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,275	6,177	759	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	85	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	1,010	1,530	1,161	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	4,917	22,547	10,848	1,076	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,916	30,427	77,918	60,820	43,743	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	0	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	54,916	30,427	77,918	60,820	43,743	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/26/2022 1:16 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
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	21,393					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	6,579			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,615	0		356,059	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		0	0	31.00
43.00	04300	NURSERY	63	0		10,793	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,619	0		198,943	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	237	0		22,064	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,839	0		209,083	0	54.00
60.00	06000	LABORATORY	1,996	0		89,504	0	60.00
64.00	06400	INTRAVENOUS THERAPY	606	0		29,003	0	64.00
65.00	06500	RESPIRATORY THERAPY	453	0		33,469	0	65.00
66.00	06600	PHYSICAL THERAPY	476	0		119,816	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	92	0		24,992	0	67.00
68.00	06800	SPEECH PATHOLOGY	51	0		16,761	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	46	0		14,430	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13	0		5,491	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,502	0		77,853	0	73.00
74.00	07400	RENAL DIALYSIS	0	0		0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0		0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	314	0		179,285	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89.00
90.00	09000	CLINIC	18	0		2,325	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	247	0		94,874	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0		0	0	90.02
91.00	09100	EMERGENCY	6,206	0		211,454	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0		0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0		0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,393	0	0	1,696,199	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0		3	0	190.01
190.02	19002	OUTREACH	0	0		4,432	0	190.02
190.03	19003	FOUNDATION	0	0		0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0		0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0		67	0	190.05
190.06	19006	OTHER PROPERTY	0	0		26,360	0	190.06
191.00	19100	RESEARCH	0	0		0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		0	0	192.00
193.00	19300	NONPAID WORKERS	0	0		0	0	193.00
200.00		Cross Foot Adjustments			6,579	6,579	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,393	0	6,579	1,733,640	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 1:16 pm

		Cost Center Description	Total	
			26.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	UTILITIES		7.01
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	356,059	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	10,793	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	198,943	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	22,064	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	209,083	54.00
60.00	06000	LABORATORY	89,504	60.00
64.00	06400	INTRAVENOUS THERAPY	29,003	64.00
65.00	06500	RESPIRATORY THERAPY	33,469	65.00
66.00	06600	PHYSICAL THERAPY	119,816	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,992	67.00
68.00	06800	SPEECH PATHOLOGY	16,761	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,430	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,853	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	179,285	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	2,325	90.00
90.01	09001	VISITING SPECIALTY CLINIC	94,874	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	90.02
91.00	09100	EMERGENCY	211,454	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,696,199	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	3	190.01
190.02	19002	OUTREACH	4,432	190.02
190.03	19003	FOUNDATION	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	67	190.05
190.06	19006	OTHER PROPERTY	26,360	190.06
191.00	19100	RESEARCH	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
200.00		Cross Foot Adjustments	6,579	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,733,640	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 1:16 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	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	CAP REL COSTS-BLDG & FIXT	63,085					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		59,775				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	744	744	10,045,975			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,630	3,630	691,181	-7,557,275	21,816,955	5.00
7.00	00700	OPERATION OF PLANT	4,448	4,448	438,259	0	1,426,234	7.00
7.01	00701	UTILITIES	0	0	0	0	371,388	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	300	300	0	0	78,882	8.00
9.00	00900	HOUSEKEEPING	886	886	230,648	0	510,874	9.00
10.00	01000	DIETARY	1,779	1,779	95,039	0	312,715	10.00
11.00	01100	CAFETERIA	977	977	67,908	0	187,034	11.00
13.00	01300	NURSING ADMINISTRATION	1,874	1,874	960,623	0	1,460,199	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,061	2,061	0	0	286,898	14.00
15.00	01500	PHARMACY	1,169	1,169	266,490	0	595,091	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	753	753	0	0	18,305	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	350,338	0	324,333	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,471	7,471	1,409,930	0	2,170,361	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	250	250	36,390	0	59,124	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,027	6,027	485,895	0	861,495	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	501	501	157,906	0	242,366	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,986	5,986	918,754	0	1,757,099	54.00
60.00	06000	LABORATORY	1,904	1,904	0	0	1,959,847	60.00
64.00	06400	INTRAVENOUS THERAPY	768	768	121,846	0	198,318	64.00
65.00	06500	RESPIRATORY THERAPY	487	487	341,822	0	507,508	65.00
66.00	06600	PHYSICAL THERAPY	4,137	4,137	430,253	0	804,903	66.00
67.00	06700	OCCUPATIONAL THERAPY	871	871	90,612	0	155,705	67.00
68.00	06800	SPEECH PATHOLOGY	584	584	60,763	0	104,412	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	75,139	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	28,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,077,598	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,998	4,968	1,186,527	0	1,737,750	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	38	38	42,379	0	69,340	90.00
90.01	09001	VISITING SPECIALTY CLINIC	3,039	3,039	173,023	0	347,727	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	4,123	4,123	1,489,389	0	3,053,488	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,805	59,775	10,045,975	-7,557,275	21,782,746	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	203	190.01
190.02	19002	OUTREACH	448	0	0	0	4,060	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	4,272	190.05
190.06	19006	OTHER PROPERTY	2,832	0	0	0	25,655	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	19	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	571,488	911,663	2,021,924		7,557,275	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.059016	15.251577	0.201267		0.346395	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			18,087		339,980	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 1:16 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001800		0.015583	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: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 1:16 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	44,885					7.00
7.01	00701	UTILITIES	0	53,785				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	300	300	1,671			8.00
9.00	00900	HOUSEKEEPING	886	886	0	46,985		9.00
10.00	01000	DIETARY	1,779	1,779	0	1,779	7,564	10.00
11.00	01100	CAFETERIA	977	977	0	977	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,199	1,874	0	1,874	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,061	2,061	0	0	0	14.00
15.00	01500	PHARMACY	1,169	1,169	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	753	753	0	753	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,471	7,471	1,515	7,471	7,564	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	250	250	156	250	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,027	6,027	0	6,027	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	501	501	0	501	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,986	5,986	0	5,986	0	54.00
60.00	06000	LABORATORY	1,904	1,904	0	1,904	0	60.00
64.00	06400	INTRAVENOUS THERAPY	768	768	0	768	0	64.00
65.00	06500	RESPIRATORY THERAPY	487	487	0	487	0	65.00
66.00	06600	PHYSICAL THERAPY	147	4,137	0	4,137	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	31	871	0	871	0	67.00
68.00	06800	SPEECH PATHOLOGY	21	584	0	584	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,968	4,968	0	4,968	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	38	38	0	38	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	3,039	3,039	0	3,039	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	4,123	4,123	0	4,123	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,885	50,953	1,671	46,537	7,564	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	448	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	2,832	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	1,920,274	500,035	121,830	733,980	541,477	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	42.782088	9.296923	72.908438	15.621581	71.586066	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	131,148	5,787	9,431	32,599	54,916	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.921867	0.107595	5.643926	0.693817	7.260180	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 Date/Time Prepared: 5/26/2022 1:16 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			7.00	7.01	8.00	9.00	10.00	
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: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 1:16 pm

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	234,085					11.00
13.00	01300	NURSING ADMINISTRATION	22,095	87,190				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	345,832			14.00
15.00	01500	PHARMACY	7,709	0	5,839	2,165,060		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	86,359,337	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	4,160	0	1,966	358	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,210	35,678	46,368	14,996	6,510,152	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	837	835	5,607	672	255,097	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,651	8,571	27,992	4,822	6,526,354	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,632	3,624	49	0	955,181	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,654	1,762	19,008	7,240	15,478,149	54.00
60.00	06000	LABORATORY	23,967	0	2,713	0	8,048,836	60.00
64.00	06400	INTRAVENOUS THERAPY	2,873	2,866	2,842	6,116	2,445,450	64.00
65.00	06500	RESPIRATORY THERAPY	7,180	0	56,331	0	1,825,236	65.00
66.00	06600	PHYSICAL THERAPY	12,354	0	563	0	1,920,350	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,516	0	119	0	371,185	67.00
68.00	06800	SPEECH PATHOLOGY	1,804	0	80	0	205,292	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	75,139	0	184,687	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	28,612	0	52,474	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,077,597	14,120,064	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	25,192	6,912	4,318	0	1,266,115	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	657	0	0	0	73,272	90.00
90.01	09001	VISITING SPECIALTY CLINIC	7,769	1,712	6,601	0	995,520	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	37,825	25,230	61,685	53,259	25,125,923	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	234,085	87,190	345,832	2,165,060	86,359,337	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	0	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	317,965	2,094,010	493,613	880,913	75,625	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.358331	24.016630	1.427320	0.406877	0.000876	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	30,427	77,918	60,820	43,743	21,393	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.129983	0.893658	0.175866	0.020204	0.000248	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 1:16 pm

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 1:16 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			17.00	19.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	UTILITIES			7.01
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	0	0	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	100	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	90.02
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	100	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	190.01
190.02	19002	OUTREACH	0	0	190.02
190.03	19003	FOUNDATION	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	190.06
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	445,283	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	4,452.830000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	6,579	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	65.790000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 1:16 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			17.00	19.00		
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: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/26/2022 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,065,284		5,065,284	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	137,593		137,593	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,281,176		2,281,176	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	453,114		453,114	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,891,804		2,891,804	0	0	54.00
60.00	06000	LABORATORY	2,811,107		2,811,107	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	400,428		400,428	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	808,031	0	808,031	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,212,360	0	1,212,360	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	236,583	0	236,583	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	158,774	0	158,774	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	208,578		208,578	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	79,408		79,408	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,654,963		3,654,963	0	0	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,883,528		2,883,528	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	96,888		96,888	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	735,883		735,883	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0		0	0	0	90.02
91.00	09100	EMERGENCY	5,179,342		5,179,342	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,165,694		1,165,694		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	30,460,538	0	30,460,538	0	0	200.00
201.00		Less Observation Beds	1,165,694		1,165,694		0	201.00
202.00		Total (see instructions)	29,294,844	0	29,294,844	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/26/2022 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	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	3,612,291		3,612,291			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	255,097		255,097			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	693,619	5,832,735	6,526,354	0.349533	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	610,798	344,383	955,181	0.474375	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	502,563	14,975,586	15,478,149	0.186831	0.000000	54.00
60.00	06000	LABORATORY	1,059,327	6,989,509	8,048,836	0.349256	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	2,445,450	2,445,450	0.163744	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	643,280	1,181,956	1,825,236	0.442699	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	180,480	1,739,870	1,920,350	0.631322	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	92,926	278,259	371,185	0.637372	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	19,977	185,315	205,292	0.773406	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,496	171,191	184,687	1.129359	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	52,474	52,474	1.513283	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,631,827	10,488,237	14,120,064	0.258849	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,266,115	1,266,115			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	73,272	73,272	1.322306	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	995,520	995,520	0.739195	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	385,739	24,740,184	25,125,923	0.206135	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	12,238	2,885,623	2,897,861	0.402260	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,713,658	74,645,679	86,359,337			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,713,658	74,645,679	86,359,337			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/26/2022 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	90.02
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/26/2022 1:16 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,065,284		5,065,284	0	5,065,284	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	137,593		137,593	0	137,593	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,281,176		2,281,176	0	2,281,176	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	453,114		453,114	0	453,114	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,891,804		2,891,804	0	2,891,804	54.00
60.00	06000	LABORATORY	2,811,107		2,811,107	0	2,811,107	60.00
64.00	06400	INTRAVENOUS THERAPY	400,428		400,428	0	400,428	64.00
65.00	06500	RESPIRATORY THERAPY	808,031	0	808,031	0	808,031	65.00
66.00	06600	PHYSICAL THERAPY	1,212,360	0	1,212,360	0	1,212,360	66.00
67.00	06700	OCCUPATIONAL THERAPY	236,583	0	236,583	0	236,583	67.00
68.00	06800	SPEECH PATHOLOGY	158,774	0	158,774	0	158,774	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	208,578		208,578	0	208,578	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	79,408		79,408	0	79,408	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,654,963		3,654,963	0	3,654,963	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,883,528		2,883,528	0	2,883,528	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	96,888		96,888	0	96,888	90.00
90.01	09001	VISITING SPECIALTY CLINIC	735,883		735,883	0	735,883	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0		0	0	0	90.02
91.00	09100	EMERGENCY	5,179,342		5,179,342	0	5,179,342	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,165,694		1,165,694		1,165,694	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	30,460,538	0	30,460,538	0	30,460,538	200.00
201.00		Less Observation Beds	1,165,694		1,165,694		1,165,694	201.00
202.00		Total (see instructions)	29,294,844	0	29,294,844	0	29,294,844	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/26/2022 1:16 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	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	3,612,291		3,612,291			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	255,097		255,097			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	693,619	5,832,735	6,526,354	0.349533	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	610,798	344,383	955,181	0.474375	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	502,563	14,975,586	15,478,149	0.186831	0.000000	54.00
60.00	06000	LABORATORY	1,059,327	6,989,509	8,048,836	0.349256	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	2,445,450	2,445,450	0.163744	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	643,280	1,181,956	1,825,236	0.442699	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	180,480	1,739,870	1,920,350	0.631322	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	92,926	278,259	371,185	0.637372	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	19,977	185,315	205,292	0.773406	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,496	171,191	184,687	1.129359	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	52,474	52,474	1.513283	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,631,827	10,488,237	14,120,064	0.258849	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,266,115	1,266,115	2.277461	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	73,272	73,272	1.322306	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	995,520	995,520	0.739195	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	385,739	24,740,184	25,125,923	0.206135	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	12,238	2,885,623	2,897,861	0.402260	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,713,658	74,645,679	86,359,337			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,713,658	74,645,679	86,359,337			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/26/2022 1:16 pm

Title XIX | 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	0.349533	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.474375	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186831	54.00
60.00	06000	LABORATORY	0.349256	60.00
64.00	06400	INTRAVENOUS THERAPY	0.163744	64.00
65.00	06500	RESPIRATORY THERAPY	0.442699	65.00
66.00	06600	PHYSICAL THERAPY	0.631322	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.637372	67.00
68.00	06800	SPEECH PATHOLOGY	0.773406	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.129359	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.513283	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.258849	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	2.277461	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
90.00	09000	CLINIC	1.322306	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.739195	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	90.02
91.00	09100	EMERGENCY	0.206135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.402260	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part II | Date/Time Prepared: 5/26/2022 1:16 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,281,176	198,943	2,082,233	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	453,114	22,064	431,050	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,891,804	209,083	2,682,721	0	0	54.00
60.00	06000	LABORATORY	2,811,107	89,504	2,721,603	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	400,428	29,003	371,425	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	808,031	33,469	774,562	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,212,360	119,816	1,092,544	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	236,583	24,992	211,591	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	158,774	16,761	142,013	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	208,578	14,430	194,148	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	79,408	5,491	73,917	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,654,963	77,853	3,577,110	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,883,528	179,285	2,704,243	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	96,888	2,325	94,563	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	735,883	94,874	641,009	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	5,179,342	211,454	4,967,888	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,165,694	81,941	1,083,753	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	25,257,661	1,411,288	23,846,373	0	0	200.00
201.00		Less Observation Beds	1,165,694	81,941	1,083,753	0	0	201.00
202.00		Total (line 200 minus line 201)	24,091,967	1,329,347	22,762,620	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part II | Date/Time Prepared: 5/26/2022 1:16 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,281,176	6,526,354	0.349533	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	453,114	955,181	0.474375	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,891,804	15,478,149	0.186831	54.00
60.00	06000	LABORATORY	2,811,107	8,048,836	0.349256	60.00
64.00	06400	INTRAVENOUS THERAPY	400,428	2,445,450	0.163744	64.00
65.00	06500	RESPIRATORY THERAPY	808,031	1,825,236	0.442699	65.00
66.00	06600	PHYSICAL THERAPY	1,212,360	1,920,350	0.631322	66.00
67.00	06700	OCCUPATIONAL THERAPY	236,583	371,185	0.637372	67.00
68.00	06800	SPEECH PATHOLOGY	158,774	205,292	0.773406	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	208,578	184,687	1.129359	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	79,408	52,474	1.513283	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,654,963	14,120,064	0.258849	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	2,883,528	1,266,115	2.277461	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	89.00
90.00	09000	CLINIC	96,888	73,272	1.322306	90.00
90.01	09001	VISITING SPECIALTY CLINIC	735,883	995,520	0.739195	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0.000000	90.02
91.00	09100	EMERGENCY	5,179,342	25,125,923	0.206135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,165,694	2,897,861	0.402260	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000	101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (sum of lines 50 thru 199)	25,257,661	82,491,949		200.00
201.00		Less Observation Beds	1,165,694	0		201.00
202.00		Total (line 200 minus line 201)	24,091,967	82,491,949		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II | Date/Time Prepared: 5/26/2022 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	198,943	6,526,354	0.030483	7,572	231	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	22,064	955,181	0.023099	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	209,083	15,478,149	0.013508	201,182	2,718	54.00
60.00	06000	LABORATORY	89,504	8,048,836	0.011120	307,997	3,425	60.00
64.00	06400	INTRAVENOUS THERAPY	29,003	2,445,450	0.011860	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	33,469	1,825,236	0.018337	185,138	3,395	65.00
66.00	06600	PHYSICAL THERAPY	119,816	1,920,350	0.062393	83,556	5,213	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,992	371,185	0.067330	38,021	2,560	67.00
68.00	06800	SPEECH PATHOLOGY	16,761	205,292	0.081645	10,083	823	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,430	184,687	0.078132	1,574	123	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,491	52,474	0.104642	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,853	14,120,064	0.005514	1,395,363	7,694	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	179,285	1,266,115	0.141602	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	2,325	73,272	0.031731	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	94,874	995,520	0.095301	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY	211,454	25,125,923	0.008416	9,221	78	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	81,941	2,897,861	0.028276	4,960	140	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,411,288	82,491,949		2,244,667	26,400	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/26/2022 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	445,283	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	445,283	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306

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

Worksheet D Part IV

Date/Time Prepared: 5/26/2022 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	445,283	0	6,526,354	0.068228	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	955,181	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,478,149	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	8,048,836	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,445,450	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,825,236	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,920,350	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	371,185	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	205,292	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	184,687	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	52,474	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,120,064	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,266,115	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	73,272	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	995,520	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	25,125,923	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,897,861	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	445,283	0	82,491,949		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/26/2022 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	7,572	517	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	201,182	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	307,997	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	185,138	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	83,556	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	38,021	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	10,083	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,574	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,395,363	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	9,221	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	4,960	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		2,244,667	517	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/26/2022 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.349533	0	1,134,448	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.474375	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186831	0	3,612,435	0	0	54.00
60.00	06000	LABORATORY	0.349256	0	1,534,098	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.163744	0	753,345	14,294	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.442699	0	247,520	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.631322	0	516,180	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.637372	0	68,878	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.773406	0	11,985	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.129359	0	15,084	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.513283	0	7,447	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.258849	0	4,911,319	233	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	1.322306	0	35,415	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.739195	0	316,398	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.206135	0	5,481,415	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.402260	0	886,251	42,883	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	19,532,218	57,410	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	19,532,218	57,410	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/26/2022 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	396,527	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	674,915	0	54.00
60.00	06000	LABORATORY	535,793	0	60.00
64.00	06400	INTRAVENOUS THERAPY	123,356	2,341	64.00
65.00	06500	RESPIRATORY THERAPY	109,577	0	65.00
66.00	06600	PHYSICAL THERAPY	325,876	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	43,901	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,269	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,035	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,269	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,271,290	60	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	46,829	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	233,880	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	90.02
91.00	09100	EMERGENCY	1,129,911	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	356,503	17,250	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	5,285,931	19,651	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	5,285,931	19,651	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part I Date/Time Prepared: 5/26/2022 1:16 pm

Title XIX | 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	356,059	12,217	343,842	1,989	172.87	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
43.00	NURSERY	10,793		10,793	156	69.19	43.00
200.00	Total (lines 30 through 199)	366,852		354,635	2,145		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	36	6,223	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
43.00	NURSERY	12	830	43.00
200.00	Total (lines 30 through 199)	48	7,053	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/26/2022 1:16 pm

Title XIX | 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	198,943	6,526,354	0.030483	26,770	816	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	22,064	955,181	0.023099	16,067	371	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	209,083	15,478,149	0.013508	16,214	219	54.00
60.00	06000	LABORATORY	89,504	8,048,836	0.011120	23,769	264	60.00
64.00	06400	INTRAVENOUS THERAPY	29,003	2,445,450	0.011860	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	33,469	1,825,236	0.018337	18,118	332	65.00
66.00	06600	PHYSICAL THERAPY	119,816	1,920,350	0.062393	4,123	257	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,992	371,185	0.067330	3,042	205	67.00
68.00	06800	SPEECH PATHOLOGY	16,761	205,292	0.081645	1,895	155	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,430	184,687	0.078132	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,491	52,474	0.104642	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,853	14,120,064	0.005514	48,840	269	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	179,285	1,266,115	0.141602	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	2,325	73,272	0.031731	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	94,874	995,520	0.095301	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY	211,454	25,125,923	0.008416	21,762	183	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	81,941	2,897,861	0.028276	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,411,288	82,491,949		180,600	3,071	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part III Date/Time Prepared: 5/26/2022 1:16 pm

Title XIX | 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	1,989	0.00	36	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00
43.00	04300	NURSERY		0	156	0.00	12	43.00
200.00		Total (lines 30 through 199)		0	2,145		48	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: 15-1306

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

Worksheet D Part IV Date/Time Prepared: 5/26/2022 1:16 pm

Title XIX | 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	445,283	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	445,283	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306

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

Worksheet D Part IV

Date/Time Prepared: 5/26/2022 1:16 pm

Title XIX | 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	445,283	0	6,526,354	0.068228	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	955,181	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,478,149	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	8,048,836	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,445,450	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,825,236	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,920,350	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	371,185	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	205,292	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	184,687	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	52,474	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,120,064	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,266,115	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	73,272	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	995,520	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	25,125,923	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,897,861	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	445,283	0	82,491,949		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/26/2022 1:16 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	26,770	1,826	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	16,067	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	16,214	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	23,769	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	18,118	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	4,123	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,042	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,895	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	48,840	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	21,762	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		180,600	1,826	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 1:16 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,124	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,989	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)	1,515	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	64	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	71	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)	614	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)	64	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,065,284	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)	16,408	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)	173,801	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,891,483	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)	4,891,483	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)	2,459.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,509,992	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)	1,509,992	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 1:16 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	681,409	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,191,401	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	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)	157,393	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)	157,393	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)	474	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,459.27	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,165,694	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 1:16 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	356,059	5,065,284	0.070294	1,165,694	81,941	90.00
91.00	Nursing Program cost	0	5,065,284	0.000000	1,165,694	0	91.00
92.00	Allied health cost	0	5,065,284	0.000000	1,165,694	0	92.00
93.00	All other Medical Education	0	5,065,284	0.000000	1,165,694	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 1:16 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,124	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,989	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)	1,515	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	64	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	71	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)	36	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)	156	15.00
16.00	Nursery days (title V or XIX only)	12	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,065,284	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)	16,408	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)	173,801	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,891,483	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)	4,891,483	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)	2,459.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	88,534	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)	88,534	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 1:16 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	137,593	156	882.01	12	10,584	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description	1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	59,466	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	158,584	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)	7,053	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	4,897	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	11,950	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	146,634	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)	474	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,459.27	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,165,694	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 1:16 pm

Title XIX | 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	356,059	5,065,284	0.070294	1,165,694	81,941	90.00
91.00	Nursing Program cost	0	5,065,284	0.000000	1,165,694	0	91.00
92.00	Allied health cost	0	5,065,284	0.000000	1,165,694	0	92.00
93.00	All other Medical Education	0	5,065,284	0.000000	1,165,694	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,335,839		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.349533	7,572	2,647	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.474375	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186831	201,182	37,587	54.00
60.00	06000	LABORATORY	0.349256	307,997	107,570	60.00
64.00	06400	INTRAVENOUS THERAPY	0.163744	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.442699	185,138	81,960	65.00
66.00	06600	PHYSICAL THERAPY	0.631322	83,556	52,751	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.637372	38,021	24,234	67.00
68.00	06800	SPEECH PATHOLOGY	0.773406	10,083	7,798	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.129359	1,574	1,778	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.513283	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.258849	1,395,363	361,188	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	1.322306	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.739195	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.206135	9,221	1,901	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.402260	4,960	1,995	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,244,667	681,409	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)		2,244,667		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1306 | Component CCN: 15-Z306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 1:16 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.349533	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.474375	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186831	4,982	931	54.00
60.00	06000	LABORATORY	0.349256	9,621	3,360	60.00
64.00	06400	INTRAVENOUS THERAPY	0.163744	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.442699	20,327	8,999	65.00
66.00	06600	PHYSICAL THERAPY	0.631322	14,015	8,848	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.637372	6,175	3,936	67.00
68.00	06800	SPEECH PATHOLOGY	0.773406	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.129359	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.513283	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.258849	23,148	5,992	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	1.322306	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.739195	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.206135	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.402260	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		78,268	32,066	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)		78,268		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 1:16 pm

Title XIX | 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		78,124		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		18,668		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.349533	26,770	9,357	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.474375	16,067	7,622	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186831	16,214	3,029	54.00
60.00	06000	LABORATORY	0.349256	23,769	8,301	60.00
64.00	06400	INTRAVENOUS THERAPY	0.163744	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.442699	18,118	8,021	65.00
66.00	06600	PHYSICAL THERAPY	0.631322	4,123	2,603	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.637372	3,042	1,939	67.00
68.00	06800	SPEECH PATHOLOGY	0.773406	1,895	1,466	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.129359	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.513283	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.258849	48,840	12,642	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	2.277461	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	1.322306	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.739195	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.206135	21,762	4,486	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.402260	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		180,600	59,466	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)		180,600		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1306	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 1:16 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,305,582	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,305,582	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	5,358,638	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	64,902	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,346,827	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)	1,946,909	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)	1,946,909	30.00
31.00	Primary payer payments	3,918	31.00
32.00	Subtotal (line 30 minus line 31)	1,942,991	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)	926,323	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	602,110	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	781,745	36.00
37.00	Subtotal (see instructions)	2,545,101	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)	2,545,101	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	3,834,987	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)	-1,289,886	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	146,348	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: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I Date/Time Prepared: 5/26/2022 1:16 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,097,112		3,834,987	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	10/28/2021	314,600		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		314,600		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,411,712		3,834,987	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		386,908		1,289,886	6.02
7.00	Total Medicare program liability (see instructions)		2,024,804		2,545,101	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1306 | Component CCN: 15-Z306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2022 1:16 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		208,640		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		208,640		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		17,286		0	6.02
7.00	Total Medicare program liability (see instructions)		191,354		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1306	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/26/2022 1:16 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1306 | Component CCN: 15-Z306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-2 | Date/Time Prepared: 5/26/2022 1:16 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	158,967	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	32,387	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	64	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	191,354	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	191,354	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	191,354	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	191,354	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	191,354	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	208,640	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	-17,286	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	4,956	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-3 Part V Date/Time Prepared: 5/26/2022 1:16 pm

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,191,401	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,191,401	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,213,315	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,213,315	19.00
20.00	Deductibles (exclude professional component)	198,096	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,015,219	22.00
23.00	Coinsurance	742	23.00
24.00	Subtotal (line 22 minus line 23)	2,014,477	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	15,888	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	10,327	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	11,796	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,024,804	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,024,804	30.00
30.01	Sequestration adjustment (see instructions)	0	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,411,712	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-386,908	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	57,301	34.00

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

Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/26/2022 1:16 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	20,329,784	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	51,168	0	0	0	3.00
4.00	Accounts receivable	4,089,520	0	0	0	4.00
5.00	Other receivable	294,383	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	749,099	0	0	0	7.00
8.00	Prepaid expenses	107,812	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	25,621,766	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	183,505	0	0	0	12.00
13.00	Land improvements	625,604	0	0	0	13.00
14.00	Accumulated depreciation	-414,802	0	0	0	14.00
15.00	Buildings	9,679,689	0	0	0	15.00
16.00	Accumulated depreciation	-3,979,336	0	0	0	16.00
17.00	Leasehold improvements	791,602	0	0	0	17.00
18.00	Accumulated depreciation	-791,602	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	39,582	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	12,126,092	0	0	0	23.00
24.00	Accumulated depreciation	-8,314,475	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)	9,945,859	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,116,806	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	10,851,002	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	12,967,808	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	48,535,433	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,919,841	0	0	0	37.00
38.00	Salaries, wages, and fees payable	695,250	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	1,660,519				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,584,633	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,860,243	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	29,249	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	29,249	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	9,889,492	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	38,645,941				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)	38,645,941	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	48,535,433	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 | Date/Time Prepared: 5/26/2022 1:16 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		27,662,104		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		10,889,334				2.00
3.00	Total (sum of line 1 and line 2)		38,551,438		0		3.00
4.00	DONATED PPE	94,500		0		0	4.00
5.00	ROUNDING	3		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)		94,503		0		10.00
11.00	Subtotal (line 3 plus line 10)		38,645,941		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)		38,645,941		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	DONATED PPE		0		4.00
5.00	ROUNDING		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: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2022 1:16 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,742,551		3,742,551	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	124,838		124,838	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)	3,867,389		3,867,389	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,867,389		3,867,389	17.00
18.00	Ancillary services	7,448,294	44,684,966	52,133,260	18.00
19.00	Outpatient services	397,977	28,694,598	29,092,575	19.00
20.00	RURAL HEALTH CLINIC	0	1,266,115	1,266,115	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER NRCC	0	31,264	31,264	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,713,660	74,676,943	86,390,603	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		29,695,090		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)		29,695,090		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-3 | Date/Time Prepared: 5/26/2022 1:16 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	86,390,603	1.00
2.00	Less contractual allowances and discounts on patients' accounts	52,808,389	2.00
3.00	Net patient revenues (line 1 minus line 2)	33,582,214	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,695,090	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,887,124	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	1,444,618	24.00
24.50	COVID-19 PHE Funding	5,557,592	24.50
25.00	Total other income (sum of lines 6-24)	7,002,210	25.00
26.00	Total (line 5 plus line 25)	10,889,334	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)	10,889,334	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1306 | Component CCN: 15-8557 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/26/2022 1:16 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	455,433	64,196	519,629	-8,412	511,217	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	329,003	59,543	388,546	-36,622	351,924	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	395,609	0	395,609	1,515	397,124	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,180,045	123,739	1,303,784	-43,519	1,260,265	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	22,437	22,437	-846	21,591	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	22,437	22,437	-846	21,591	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,180,045	146,176	1,326,221	-44,365	1,281,856	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	216,078	216,078	-203,579	12,499	29.00
30.00	Administrative Costs	0	277,489	277,489	-166,670	110,819	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	493,567	493,567	-370,249	123,318	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,180,045	639,743	1,819,788	-414,614	1,405,174	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1306 | Component CCN: 15-8557 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/26/2022 1:16 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	511,217	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	351,924	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	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	397,124	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,260,265	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	21,591	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	21,591	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,281,856	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	36,909	49,408	29.00
30.00	Administrative Costs	-64,189	46,630	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-27,280	96,038	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-27,280	1,377,894	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1306 Component CCN: 15-8557	Period: From 01/01/2021 To 12/31/2021	Worksheet M-2 Date/Time Prepared: 5/26/2022 1:16 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	1.70	3,766	4,200	7,140		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	1.80	3,384	2,100	3,780		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.50	7,150		10,920	10,920	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.50	7,150			10,920	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,281,856	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,281,856	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)	96,038	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,505,634	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,601,672	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,601,672	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,601,672	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,883,528	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1306 Component CCN: 15-8557	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/26/2022 1:16 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)		2,883,528	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		6,813	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		2,876,715	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		10,920	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		10,920	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		263.44	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)	263.44	263.44	8.00
9.00	Rate for Program covered visits (see instructions)	263.44	263.44	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	117	534	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	30,822	140,677	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	171,499	16.00
16.01	Total program charges (see instructions)(from contractor's records)		114,121	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		11,498	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		17,279	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.)		117,835	16.04
16.05	Total program cost (see instructions)	0	135,114	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,926	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		19,139	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		135,114	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,778	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		136,892	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)		136,892	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		105,666	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)		31,226	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		699	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1306 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4

Component CCN: 15-8557 | Date/Time Prepared: 5/26/2022 1:16 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)	1,260,265	1,260,265	1,260,265	1,260,265	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000117	0.000960	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	147	1,210	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	355	1,316	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	502	2,526	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,281,856	1,281,856	1,281,856	1,281,856	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,601,672	1,601,672	1,601,672	1,601,672	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000392	0.001971	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	628	3,157	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,130	5,683	0	0	10.00
11.00	Total number of injections/infusions (from your records)	25	82	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	45.20	69.30	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	1	25	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)	45	1,733	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)		6,813			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)		1,778			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1306 Component CCN: 15-8557	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/26/2022 1:16 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		105,666	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			0	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)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		105,666	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		31,226	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		136,892	7.00

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