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: 15-3047	Period: From 05/28/2020 To 04/30/2021	Worksheet S Parts I-III Date/Time Prepared: 9/28/2021 10:35 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 9/28/2021 Time: 10:35 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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 the Balance Sheet and Statement of Revenue and Expenses prepared by Rehabilitation Hospital of Northern Indiana (15-3047) for the cost reporting period beginning 05/28/2020 and ending 04/30/2021 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.

[X] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) CLINT FEGAN
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

	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	122,328	0	0	-3,422	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	122,328	0	0	-3,422	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: 15-3047	Period: From 05/28/2020 To 04/30/2021	Worksheet S-2 Part I Date/Time Prepared: 9/28/2021 10:35 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 4807 Edison Lakes Parkway	PO Box:			1.00
2.00	City: Mishawaka	State: IN	Zip Code: 46545	County: ST. JOSEPH	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	Rehabilitation Hospital of Northern Indiana	153047	43780	5	05/28/2020	N	P	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									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									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)	05/28/2020	04/30/2021	20.00
21.00	Type of Control (see instructions)	4		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
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.	2	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 9/28/2021 10:35 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
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.	7	0	0	0	393		25.00

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	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. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet S-2 Part I | Date/Time Prepared: 9/28/2021 10:35 am

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

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

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-3047	Period: From 05/28/2020 To 04/30/2021	Worksheet S-2 Part I Date/Time Prepared: 9/28/2021 10:35 am

		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.	Y			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)	N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-3047	Period: From 05/28/2020 To 04/30/2021	Worksheet S-2 Part I Date/Time Prepared: 9/28/2021 10:35 am

		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	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			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)			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.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet S-2 Part I | Date/Time Prepared: 9/28/2021 10:35 am

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
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	HB1609	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet S-2 Part I | Date/Time Prepared: 9/28/2021 10:35 am

	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: ERNEST HEALTH INC	Contractor's Name: NOVITAS SOLUTIONS	Contractor's Number: 04011	141.00
142.00	Street: PO BOX 93758	PO Box:		142.00
143.00	City: ALBUQUERQUE	State: NM	Zip Code: 87199	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	N	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.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet S-2 Part II | Date/Time Prepared: 9/28/2021 10:35 am

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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		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 nursing school? 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 school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	09/21/2021	Y	09/21/2021	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet S-2 Part II Date/Time Prepared: 9/28/2021 10:35 am

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		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.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		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.		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.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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.	Mary	Pitcock	41.00
42.00	Enter the employer/company name of the cost report preparer.	ERNEST HEALTH INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	903-588-0077	marykay@ernesthealth.com	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-3047	Period: From 05/28/2020 To 04/30/2021	Worksheet S-2 Part II Date/Time Prepared: 9/28/2021 10:35 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	Sr. Reimbursement Analyst		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: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet S-3 Part I Date/Time Prepared: 9/28/2021 10:35 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	40	14,573	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		40	14,573	0.00	0	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)		40	14,573	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	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						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		40				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: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet S-3 Part I | Date/Time Prepared: 9/28/2021 10:35 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,069	7	5,229			1.00
2.00	HMO and other (see instructions)	921	393				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,069	7	5,229			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)	3,069	7	5,229	0.00	62.23	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	0	0	0	0.00	0.00	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)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						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	62.23	27.00
28.00	Observation Bed Days		0	0			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: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet S-3 Part I | Date/Time Prepared: 9/28/2021 10:35 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	225	1	343	1.00
2.00	HMO and other (see instructions)			49	26		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	225	1	343	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	0.00					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						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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet A | Date/Time Prepared: 9/28/2021 10:35 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,277,819	2,277,819	9,231	2,287,050	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		926,923	926,923	177,639	1,104,562	2.00
3.00	00300	OTHER CAP REL COSTS		186,870	186,870	-186,870	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	258,525	604,206	862,731	0	862,731	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,271,314	1,147,620	2,418,934	0	2,418,934	5.00
7.00	00700	OPERATION OF PLANT	39,941	283,215	323,156	0	323,156	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	35,347	35,347	0	35,347	8.00
9.00	00900	HOUSEKEEPING	82,415	27,216	109,631	0	109,631	9.00
10.00	01000	DIETARY	180,686	148,196	328,882	0	328,882	10.00
13.00	01300	NURSING ADMINISTRATION	133,915	12,777	146,692	0	146,692	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,272	4,874	33,146	0	33,146	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,324,700	177,336	1,502,036	0	1,502,036	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,446	13,446	-3,021	10,425	54.00
57.00	05700	CT SCAN	0	0	0	3,021	3,021	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	11,789	11,789	0	11,789	60.00
65.00	06500	RESPIRATORY THERAPY	53,729	18,409	72,138	0	72,138	65.00
66.00	06600	PHYSICAL THERAPY	318,183	30,641	348,824	-34,342	314,482	66.00
67.00	06700	OCCUPATIONAL THERAPY	231,113	23,426	254,539	23,826	278,365	67.00
68.00	06800	SPEECH PATHOLOGY	135,773	13,022	148,795	10,516	159,311	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,099	83,581	132,680	0	132,680	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	205,358	129,070	334,428	0	334,428	73.00
74.00	07400	RENAL DIALYSIS	0	119,228	119,228	0	119,228	74.00
76.00	03950	OUTSIDE LOA SERVICES	0	45,000	45,000	0	45,000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	42	42	0	42	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		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						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,313,023	6,320,053	10,633,076	0	10,633,076	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	4,313,023	6,320,053	10,633,076	0	10,633,076	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet A | Date/Time Prepared: 9/28/2021 10:35 am

		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	108,980	2,396,030		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-25,449	1,079,113		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-5,143	857,588		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,034	2,430,968		5.00
7.00	00700	OPERATION OF PLANT	-10,950	312,206		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	35,347		8.00
9.00	00900	HOUSEKEEPING	0	109,631		9.00
10.00	01000	DIETARY	-7,095	321,787		10.00
13.00	01300	NURSING ADMINISTRATION	0	146,692		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-34	33,112		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-8	1,502,028		30.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,425		54.00
57.00	05700	CT SCAN	0	3,021		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	11,789		60.00
65.00	06500	RESPIRATORY THERAPY	0	72,138		65.00
66.00	06600	PHYSICAL THERAPY	0	314,482		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	278,365		67.00
68.00	06800	SPEECH PATHOLOGY	0	159,311		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-887	131,793		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	334,428		73.00
74.00	07400	RENAL DIALYSIS	0	119,228		74.00
76.00	03950	OUTSIDE LOA SERVICES	0	45,000		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
91.01	04951	OUTPATIENT THERAPY	0	42		91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0		93.00
		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				
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,448	10,704,524		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	MARKETING	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	71,448	10,704,524		200.00

RECLASSIFICATIONS | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet A-6 | Date/Time Prepared: 9/28/2021 10:35 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RCLS PCT THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	21,706	2,120		1.00
2.00	SPEECH PATHOLOGY	68.00	9,581	935		2.00
	TOTALS		31,287	3,055		
	B - RCLS CT FROM RADIOLOGY					
1.00	CT SCAN	57.00	0	3,021		1.00
	TOTALS		0	3,021		
500.00	Grand Total: Increases		31,287	6,076		500.00

RECLASSIFICATIONS | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet A-6 | Date/Time Prepared: 9/28/2021 10:35 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RCLS PCT THERAPY						
1.00	PHYSICAL THERAPY	66.00	31,287	3,055	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		31,287	3,055			
	B - RCLS CT FROM RADIOLOGY						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,021	0		1.00
	TOTALS		0	3,021			
500.00	Grand Total: Decreases		31,287	6,076			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet A-7 Part I | Date/Time Prepared: 9/28/2021 10:35 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	5,414	0	5,414	0	3.00
4.00	Building Improvements	0	104,469	0	104,469	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	2,114,646	0	2,114,646	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	0	2,224,529	0	2,224,529	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	0	2,224,529	0	2,224,529	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	5,414	0	3.00
4.00	Building Improvements	104,469	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	2,114,646	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	2,224,529	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	2,224,529	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet A-7 Part II Date/Time Prepared: 9/28/2021 10:35 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	28,858	2,159,717	89,244	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	369,521	557,402	0	0	0	2.00
3.00	Total (sum of lines 1-2)	398,379	2,717,119	89,244	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	2,277,819	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	926,923	2.00
3.00	Total (sum of lines 1-2)	0	3,204,742	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet A-7 Part III Date/Time Prepared: 9/28/2021 10:35 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	109,883	0	109,883	0.049396	1,196	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,114,646	0	2,114,646	0.950604	23,011	2.00
3.00	Total (sum of lines 1-2)	2,224,529	0	2,224,529	1.000000	24,207	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	8,035	0	9,231	137,838	2,159,717	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	154,628	0	177,639	369,677	531,797	2.00
3.00	Total (sum of lines 1-2)	162,663	0	186,870	507,515	2,691,514	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	89,244	1,196	8,035	0	2,396,030	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	23,011	154,628	0	1,079,113	2.00
3.00	Total (sum of lines 1-2)	89,244	24,207	162,663	0	3,475,143	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet A-8 | Date/Time Prepared: 9/28/2021 10:35 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	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)	A	-1,032	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,942	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			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	-93,358			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-7,095	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-34	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-92	OPERATION OF PLANT	7.00	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	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INTEREST INCOME	B	-198	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet A-8 | Date/Time Prepared: 9/28/2021 10:35 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	MISC INCOME	B	-2,582	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.04	PRE-OPENING AMORTIZATION - CAP	A	75,070	CAP REL COSTS-BLDG & FIXT	1.00	9	33.04
33.05	PRE-OPENING AMORTIZATION - A&G	A	239,007	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.11	OTHER EXPENSE-ADVERTISING/MARKETING-	A	-4,940	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.13	OTHER EXPENSE-ADVERTISING/MARKETING-	A	-13,221	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.29	BAD DEBT EXPENSE-BAD DEBT--	A	-36,393	ADMINISTRATIVE & GENERAL	5.00	0	33.29
34.18	TAXES-FRANCHISE FEES/BUSINESS TAX--	A	-155	ADMINISTRATIVE & GENERAL	5.00	0	34.18
34.21	OTHER EXPENSE-GIVEAWAYS--	A	-543	ADMINISTRATIVE & GENERAL	5.00	0	34.21
34.22	OTHER EXPENSE-GIVEAWAYS--	A	-68	ADMINISTRATIVE & GENERAL	5.00	0	34.22
34.46	OTHER FEES-LATE FEES--	A	-17	ADMINISTRATIVE & GENERAL	5.00	0	34.46
34.48	OTHER FEES-LATE FEES--	A	-77	ADMINISTRATIVE & GENERAL	5.00	0	34.48
34.50	OTHER FEES-LATE FEES--	A	-5	ADMINISTRATIVE & GENERAL	5.00	0	34.50
34.65	OTHER FEES-LATE FEES--	A	-916	OPERATION OF PLANT	7.00	0	34.65
34.75	OTHER FEES-LATE FEES--	A	-8	ADULTS & PEDIATRICS	30.00	0	34.75
34.77	OTHER FEES-LATE FEES--	A	-887	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	34.77
35.23	MARKETING EXPENSE	A	-29,520	ADMINISTRATIVE & GENERAL	5.00	0	35.23
35.24	MARKETING BENEFITS	A	-3,760	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.24
35.25	TELEPHONE OPERATOR EXPENSE	A	-10,798	ADMINISTRATIVE & GENERAL	5.00	0	35.25
35.26	TELEPHONE BENEFIT EXPENSE	A	-1,383	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.26
35.27	TELEVISION LEASE	A	-25,605	CAP REL COSTS-MVBLE EQUIP	2.00	10	35.27
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		71,448				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: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet A-8-1 | Date/Time Prepared: 9/28/2021 10:35 am

	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	HO Alloc - Cap Rel Bldg	28,632	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO Alloc - Cap Rel Equipment	156	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO Alloc - Cap Rel A&G	165,056	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY MANAGEMENT FEES	0	322,740	4.00
4.03	5.00	ADMINISTRATIVE & GENERAL	PRE-OPENING AMORTIZATION - H	30,260	0	4.03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	PRE-OPENING AMORTIZATION - H	5,278	0	4.04
5.00	0		0	229,382	322,740	5.00

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

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

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

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

6.00	B		0.00	ERNEST HEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	FINANCIAL				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: 15-3047	Period: From 05/28/2020 To 04/30/2021	Worksheet A-8-1 Date/Time Prepared: 9/28/2021 10:35 am

	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	28,632	9		1.00
2.00	156	9		2.00
3.00	165,056	0		3.00
4.00	-322,740	0		4.00
4.03	30,260	0		4.03
4.04	5,278	9		4.04
5.00	-93,358			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	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet B Part I Date/Time Prepared: 9/28/2021 10:35 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,396,030	2,396,030				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,079,113		1,079,113			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	857,588	8,617	3,881	870,086		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,430,968	157,267	70,829	272,821	2,931,885	5.00
7.00	00700	OPERATION OF PLANT	312,206	712,210	320,762	8,571	1,353,749	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	35,347	0	0	0	35,347	8.00
9.00	00900	HOUSEKEEPING	109,631	52,628	23,702	17,686	203,647	9.00
10.00	01000	DIETARY	321,787	164,610	74,136	38,775	599,308	10.00
13.00	01300	NURSING ADMINISTRATION	146,692	82,481	37,147	28,738	295,058	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,112	9,321	4,198	6,067	52,698	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,502,028	845,427	380,762	284,277	3,012,494	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,425	0	0	0	10,425	54.00
57.00	05700	CT SCAN	3,021	0	0	0	3,021	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	11,789	8,529	3,841	0	24,159	60.00
65.00	06500	RESPIRATORY THERAPY	72,138	0	0	11,530	83,668	65.00
66.00	06600	PHYSICAL THERAPY	314,482	207,037	93,244	61,567	676,330	66.00
67.00	06700	OCCUPATIONAL THERAPY	278,365	35,964	16,197	54,255	384,781	67.00
68.00	06800	SPEECH PATHOLOGY	159,311	14,729	6,633	31,193	211,866	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	131,793	51,397	23,148	10,537	216,875	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	334,428	45,285	20,395	44,069	444,177	73.00
74.00	07400	RENAL DIALYSIS	119,228	0	0	0	119,228	74.00
76.00	03950	OUTSIDE LOA SERVICES	45,000	0	0	0	45,000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	42	0	0	0	42	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		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						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,704,524	2,395,502	1,078,875	870,086	10,703,758	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	528	238	0	766	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
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)	10,704,524	2,396,030	1,079,113	870,086	10,704,524	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet B Part I Date/Time Prepared: 9/28/2021 10:35 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	2,931,885					5.00
7.00	00700	OPERATION OF PLANT	510,642	1,864,391				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,333	0	48,680			8.00
9.00	00900	HOUSEKEEPING	76,817	64,639	0	345,103		9.00
10.00	01000	DIETARY	226,063	202,180	0	38,768	1,066,319	10.00
13.00	01300	NURSING ADMINISTRATION	111,298	101,306	0	19,426	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,878	11,448	0	2,195	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,136,328	1,038,391	48,680	199,111	1,066,319	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,932	0	0	0	0	54.00
57.00	05700	CT SCAN	1,140	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	9,113	10,476	0	2,009	0	60.00
65.00	06500	RESPIRATORY THERAPY	31,560	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	255,116	254,292	0	48,761	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	145,142	44,173	0	8,470	0	67.00
68.00	06800	SPEECH PATHOLOGY	79,917	18,090	0	3,469	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	81,807	63,127	0	12,105	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	167,546	55,621	0	10,665	0	73.00
74.00	07400	RENAL DIALYSIS	44,974	0	0	0	0	74.00
76.00	03950	OUTSIDE LOA SERVICES	16,974	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	16	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		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						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,931,596	1,863,743	48,680	344,979	1,066,319	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	289	648	0	124	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
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)	2,931,885	1,864,391	48,680	345,103	1,066,319	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet B Part I | Date/Time Prepared: 9/28/2021 10:35 am

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			13.00	16.00	24.00	25.00	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
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	527,088					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	86,219				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	527,088	43,050	7,071,461	0	7,071,461	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	444	14,801	0	14,801	54.00
57.00	05700	CT SCAN	0	129	4,290	0	4,290	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,632	47,389	0	47,389	60.00
65.00	06500	RESPIRATORY THERAPY	0	979	116,207	0	116,207	65.00
66.00	06600	PHYSICAL THERAPY	0	10,007	1,244,506	0	1,244,506	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,508	593,074	0	593,074	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,638	317,980	0	317,980	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,182	375,096	0	375,096	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,746	689,755	0	689,755	73.00
74.00	07400	RENAL DIALYSIS	0	1,780	165,982	0	165,982	74.00
76.00	03950	OUTSIDE LOA SERVICES	0	124	62,098	0	62,098	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	58	0	58	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		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						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	527,088	86,219	10,702,697	0	10,702,697	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	1,827	0	1,827	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
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)	527,088	86,219	10,704,524	0	10,704,524	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet B Part II Date/Time Prepared: 9/28/2021 10:35 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			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	8,617	3,881	12,498	12,498	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	157,267	70,829	228,096	3,919	5.00
7.00	00700	OPERATION OF PLANT	0	712,210	320,762	1,032,972	123	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	52,628	23,702	76,330	254	9.00
10.00	01000	DIETARY	0	164,610	74,136	238,746	557	10.00
13.00	01300	NURSING ADMINISTRATION	0	82,481	37,147	119,628	413	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,321	4,198	13,519	87	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	845,427	380,762	1,226,189	4,083	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	8,529	3,841	12,370	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	166	65.00
66.00	06600	PHYSICAL THERAPY	0	207,037	93,244	300,281	885	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	35,964	16,197	52,161	779	67.00
68.00	06800	SPEECH PATHOLOGY	0	14,729	6,633	21,362	448	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	51,397	23,148	74,545	151	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	45,285	20,395	65,680	633	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OUTSIDE LOA SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		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						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,395,502	1,078,875	3,474,377	12,498	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	528	238	766	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,396,030	1,079,113	3,475,143	12,498	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet B Part II Date/Time Prepared: 9/28/2021 10:35 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	232,015					5.00
7.00	00700	OPERATION OF PLANT	40,409	1,073,504				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,055	0	1,055			8.00
9.00	00900	HOUSEKEEPING	6,079	37,219	0	119,882		9.00
10.00	01000	DIETARY	17,889	116,414	0	13,467	387,073	10.00
13.00	01300	NURSING ADMINISTRATION	8,807	58,331	0	6,748	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,573	6,592	0	763	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	89,927	597,899	1,055	69,168	387,073	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	311	0	0	0	0	54.00
57.00	05700	CT SCAN	90	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	721	6,032	0	698	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,497	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	20,188	146,419	0	16,938	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,486	25,435	0	2,942	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,324	10,416	0	1,205	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,474	36,348	0	4,205	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,259	32,026	0	3,705	0	73.00
74.00	07400	RENAL DIALYSIS	3,559	0	0	0	0	74.00
76.00	03950	OUTSIDE LOA SERVICES	1,343	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	1	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		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						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	231,992	1,073,131	1,055	119,839	387,073	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	23	373	0	43	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
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)	232,015	1,073,504	1,055	119,882	387,073	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet B Part II | Date/Time Prepared: 9/28/2021 10:35 am

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			13.00	16.00	24.00	25.00	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
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	193,927					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,534				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	193,927	11,252	2,580,573	0	2,580,573	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	116	427	0	427	54.00
57.00	05700	CT SCAN	0	34	124	0	124	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	427	20,248	0	20,248	60.00
65.00	06500	RESPIRATORY THERAPY	0	256	2,919	0	2,919	65.00
66.00	06600	PHYSICAL THERAPY	0	2,615	487,326	0	487,326	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,746	95,549	0	95,549	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,212	40,967	0	40,967	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	309	122,032	0	122,032	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,070	118,373	0	118,373	73.00
74.00	07400	RENAL DIALYSIS	0	465	4,024	0	4,024	74.00
76.00	03950	OUTSIDE LOA SERVICES	0	32	1,375	0	1,375	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	1	0	1	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		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						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	193,927	22,534	3,473,938	0	3,473,938	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	1,205	0	1,205	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
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)	193,927	22,534	3,475,143	0	3,475,143	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet B-1 | Date/Time Prepared: 9/28/2021 10:35 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS 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	54,497					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		54,497				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	196	196	4,054,499			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,577	3,577	1,271,314	-2,931,885	7,772,639	5.00
7.00	00700	OPERATION OF PLANT	16,199	16,199	39,941	0	1,353,749	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	35,347	8.00
9.00	00900	HOUSEKEEPING	1,197	1,197	82,415	0	203,647	9.00
10.00	01000	DIETARY	3,744	3,744	180,686	0	599,308	10.00
13.00	01300	NURSING ADMINISTRATION	1,876	1,876	133,915	0	295,058	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	212	212	28,272	0	52,698	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,229	19,229	1,324,700	0	3,012,494	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	10,425	54.00
57.00	05700	CT SCAN	0	0	0	0	3,021	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	194	194	0	0	24,159	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	53,729	0	83,668	65.00
66.00	06600	PHYSICAL THERAPY	4,709	4,709	286,896	0	676,330	66.00
67.00	06700	OCCUPATIONAL THERAPY	818	818	252,820	0	384,781	67.00
68.00	06800	SPEECH PATHOLOGY	335	335	145,354	0	211,866	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,169	1,169	49,099	0	216,875	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,030	1,030	205,358	0	444,177	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	119,228	74.00
76.00	03950	OUTSIDE LOA SERVICES	0	0	0	0	45,000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	42	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		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						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,485	54,485	4,054,499	-2,931,885	7,771,873	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	12	12	0	0	766	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,396,030	1,079,113	870,086		2,931,885	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	43.966273	19.801329	0.214598		0.377206	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,498		232,015	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003083		0.029850	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: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet B-1 | Date/Time Prepared: 9/28/2021 10:35 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	NURSING ADMINISTRATION (NURSING SALARIES)	
			7.00	8.00	9.00	10.00	13.00	
		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	34,525					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,229				8.00
9.00	00900	HOUSEKEEPING	1,197	0	33,328			9.00
10.00	01000	DIETARY	3,744	0	3,744	5,229		10.00
13.00	01300	NURSING ADMINISTRATION	1,876	0	1,876	0	1,324,700	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	212	0	212	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,229	5,229	19,229	5,229	1,324,700	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	194	0	194	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,709	0	4,709	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	818	0	818	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	335	0	335	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,169	0	1,169	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,030	0	1,030	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OUTSIDE LOA SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		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						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,513	5,229	33,316	5,229	1,324,700	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	12	0	12	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
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)	1,864,391	48,680	345,103	1,066,319	527,088	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	54.001188	9.309619	10.354747	203.924077	0.397892	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,073,504	1,055	119,882	387,073	193,927	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	31.093526	0.201759	3.597036	74.024288	0.146393	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: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet B-1 | Date/Time Prepared: 9/28/2021 10:35 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			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
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,471,616		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	5,229,000		30.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,895		54.00
57.00	05700	CT SCAN	15,621		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
60.00	06000	LABORATORY	198,251		60.00
65.00	06500	RESPIRATORY THERAPY	118,839		65.00
66.00	06600	PHYSICAL THERAPY	1,215,335		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,276,185		67.00
68.00	06800	SPEECH PATHOLOGY	563,265		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	143,508		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,426,567		73.00
74.00	07400	RENAL DIALYSIS	216,150		74.00
76.00	03950	OUTSIDE LOA SERVICES	15,000		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0		91.00
91.01	04951	OUTPATIENT THERAPY	0		91.01
93.00	04950	OUTPATIENT WOUND CENTER	0		93.00
		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			
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,471,616		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	MARKETING	0		194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0		194.01
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)	86,219		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.008234		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	22,534		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002152		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet C Part I Date/Time Prepared: 9/28/2021 10:35 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,071,461		7,071,461	0	7,071,461	30.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,801		14,801	0	14,801	54.00
57.00	05700	CT SCAN	4,290		4,290	0	4,290	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	47,389		47,389	0	47,389	60.00
65.00	06500	RESPIRATORY THERAPY	116,207	0	116,207	0	116,207	65.00
66.00	06600	PHYSICAL THERAPY	1,244,506	0	1,244,506	0	1,244,506	66.00
67.00	06700	OCCUPATIONAL THERAPY	593,074	0	593,074	0	593,074	67.00
68.00	06800	SPEECH PATHOLOGY	317,980	0	317,980	0	317,980	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	375,096		375,096	0	375,096	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	689,755		689,755	0	689,755	73.00
74.00	07400	RENAL DIALYSIS	165,982		165,982	0	165,982	74.00
76.00	03950	OUTSIDE LOA SERVICES	62,098		62,098	0	62,098	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0		0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	58		58	0	58	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0		0	0	0	93.00
		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						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0		0		0	117.00
200.00		Subtotal (see instructions)	10,702,697	0	10,702,697	0	10,702,697	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	10,702,697	0	10,702,697	0	10,702,697	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet C Part I Date/Time Prepared: 9/28/2021 10:35 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,229,000		5,229,000			30.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,895	0	53,895	0.274627	0.000000	54.00
57.00	05700	CT SCAN	15,621	0	15,621	0.274630	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	198,251	0	198,251	0.239035	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	118,839	0	118,839	0.977852	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,215,335	0	1,215,335	1.024002	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,276,185	0	1,276,185	0.464724	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	563,265	0	563,265	0.564530	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	143,508	0	143,508	2.613764	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,426,567	0	1,426,567	0.483507	0.000000	73.00
74.00	07400	RENAL DIALYSIS	216,150	0	216,150	0.767902	0.000000	74.00
76.00	03950	OUTSIDE LOA SERVICES	15,000	0	15,000	4.139867	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0.000000	0.000000	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0.000000	0.000000	93.00
		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						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00		Subtotal (see instructions)	10,471,616	0	10,471,616			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,471,616	0	10,471,616			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet C Part I Date/Time Prepared: 9/28/2021 10:35 am

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.274627	54.00
57.00	05700	CT SCAN	0.274630	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.239035	60.00
65.00	06500	RESPIRATORY THERAPY	0.977852	65.00
66.00	06600	PHYSICAL THERAPY	1.024002	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.464724	67.00
68.00	06800	SPEECH PATHOLOGY	0.564530	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.613764	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.483507	73.00
74.00	07400	RENAL DIALYSIS	0.767902	74.00
76.00	03950	OUTSIDE LOA SERVICES	4.139867	76.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
91.01	04951	OUTPATIENT THERAPY	0.000000	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	93.00
		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		
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS		117.00
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: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet C Part I Date/Time Prepared: 9/28/2021 10:35 am

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		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	7,071,461		7,071,461	0	7,071,461	30.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,801		14,801	0	14,801	54.00
57.00	05700	CT SCAN	4,290		4,290	0	4,290	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	47,389		47,389	0	47,389	60.00
65.00	06500	RESPIRATORY THERAPY	116,207	0	116,207	0	116,207	65.00
66.00	06600	PHYSICAL THERAPY	1,244,506	0	1,244,506	0	1,244,506	66.00
67.00	06700	OCCUPATIONAL THERAPY	593,074	0	593,074	0	593,074	67.00
68.00	06800	SPEECH PATHOLOGY	317,980	0	317,980	0	317,980	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	375,096		375,096	0	375,096	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	689,755		689,755	0	689,755	73.00
74.00	07400	RENAL DIALYSIS	165,982		165,982	0	165,982	74.00
76.00	03950	OUTSIDE LOA SERVICES	62,098		62,098	0	62,098	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0		0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	58		58	0	58	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0		0	0	0	93.00
		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						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0		0		0	117.00
200.00		Subtotal (see instructions)	10,702,697	0	10,702,697	0	10,702,697	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	10,702,697	0	10,702,697	0	10,702,697	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet C Part I Date/Time Prepared: 9/28/2021 10:35 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,229,000		5,229,000			30.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,895	0	53,895	0.274627	0.000000	54.00
57.00	05700	CT SCAN	15,621	0	15,621	0.274630	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	198,251	0	198,251	0.239035	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	118,839	0	118,839	0.977852	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,215,335	0	1,215,335	1.024002	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,276,185	0	1,276,185	0.464724	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	563,265	0	563,265	0.564530	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	143,508	0	143,508	2.613764	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,426,567	0	1,426,567	0.483507	0.000000	73.00
74.00	07400	RENAL DIALYSIS	216,150	0	216,150	0.767902	0.000000	74.00
76.00	03950	OUTSIDE LOA SERVICES	15,000	0	15,000	4.139867	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0.000000	0.000000	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0.000000	0.000000	93.00
		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						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00		Subtotal (see instructions)	10,471,616	0	10,471,616			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,471,616	0	10,471,616			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet C Part I Date/Time Prepared: 9/28/2021 10:35 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.274627	54.00
57.00	05700	CT SCAN	0.274630	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.239035	60.00
65.00	06500	RESPIRATORY THERAPY	0.977852	65.00
66.00	06600	PHYSICAL THERAPY	1.024002	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.464724	67.00
68.00	06800	SPEECH PATHOLOGY	0.564530	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.613764	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.483507	73.00
74.00	07400	RENAL DIALYSIS	0.767902	74.00
76.00	03950	OUTSIDE LOA SERVICES	4.139867	76.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
91.01	04951	OUTPATIENT THERAPY	0.000000	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	93.00
		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		
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS		117.00
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: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet C Part II Date/Time Prepared: 9/28/2021 10:35 am

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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,801	427	14,374	0	0	54.00
57.00	05700	CT SCAN	4,290	124	4,166	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	47,389	20,248	27,141	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	116,207	2,919	113,288	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,244,506	487,326	757,180	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	593,074	95,549	497,525	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	317,980	40,967	277,013	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	375,096	122,032	253,064	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	689,755	118,373	571,382	0	0	73.00
74.00	07400	RENAL DIALYSIS	165,982	4,024	161,958	0	0	74.00
76.00	03950	OUTSIDE LOA SERVICES	62,098	1,375	60,723	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	58	1	57	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		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						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
200.00		Subtotal (sum of lines 50 thru 199)	3,631,236	893,365	2,737,871	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	3,631,236	893,365	2,737,871	0	0	202.00

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

Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet C Part II Date/Time Prepared: 9/28/2021 10:35 am

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					
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,801	53,895	0.274627		54.00
57.00	05700	CT SCAN	4,290	15,621	0.274630		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000		58.00
60.00	06000	LABORATORY	47,389	198,251	0.239035		60.00
65.00	06500	RESPIRATORY THERAPY	116,207	118,839	0.977852		65.00
66.00	06600	PHYSICAL THERAPY	1,244,506	1,215,335	1.024002		66.00
67.00	06700	OCCUPATIONAL THERAPY	593,074	1,276,185	0.464724		67.00
68.00	06800	SPEECH PATHOLOGY	317,980	563,265	0.564530		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	375,096	143,508	2.613764		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	689,755	1,426,567	0.483507		73.00
74.00	07400	RENAL DIALYSIS	165,982	216,150	0.767902		74.00
76.00	03950	OUTSIDE LOA SERVICES	62,098	15,000	4.139867		76.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0.000000		91.00
91.01	04951	OUTPATIENT THERAPY	58	0	0.000000		91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0.000000		93.00
		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					
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0.000000		117.00
200.00		Subtotal (sum of lines 50 thru 199)	3,631,236	5,242,616			200.00
201.00		Less Observation Beds	0	0			201.00
202.00		Total (line 200 minus line 201)	3,631,236	5,242,616			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D Part I Date/Time Prepared: 9/28/2021 10:35 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,580,573	0	2,580,573	5,229	493.51	30.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	2,580,573		2,580,573	5,229		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	3,069	1,514,582	30.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	3,069	1,514,582	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D Part II Date/Time Prepared: 9/28/2021 10:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	427	53,895	0.007923	29,831	236	54.00
57.00	05700	CT SCAN	124	15,621	0.007938	4,770	38	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	20,248	198,251	0.102133	111,684	11,407	60.00
65.00	06500	RESPIRATORY THERAPY	2,919	118,839	0.024563	61,263	1,505	65.00
66.00	06600	PHYSICAL THERAPY	487,326	1,215,335	0.400981	721,625	289,358	66.00
67.00	06700	OCCUPATIONAL THERAPY	95,549	1,276,185	0.074871	757,365	56,705	67.00
68.00	06800	SPEECH PATHOLOGY	40,967	563,265	0.072731	316,065	22,988	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	122,032	143,508	0.850350	100,459	85,425	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	118,373	1,426,567	0.082978	775,460	64,346	73.00
74.00	07400	RENAL DIALYSIS	4,024	216,150	0.018617	112,200	2,089	74.00
76.00	03950	OUTSIDE LOA SERVICES	1,375	15,000	0.091667	5,000	458	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	1	0	0.000000	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	893,365	5,242,616		2,995,722	534,555	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D Part III Date/Time Prepared: 9/28/2021 10:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	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
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
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	5,229	0.00	3,069	30.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	5,229		3,069	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
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D Part IV | Date/Time Prepared: 9/28/2021 10:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
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
76.00	03950	OUTSIDE LOA SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D Part IV Date/Time Prepared: 9/28/2021 10:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	53,895	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	15,621	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	198,251	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	118,839	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,215,335	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,276,185	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	563,265	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	143,508	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,426,567	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	216,150	0.000000	74.00
76.00	03950	OUTSIDE LOA SERVICES	0	0	0	15,000	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0.000000	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	5,242,616		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D Part IV | Date/Time Prepared: 9/28/2021 10:35 am

Title XVIII | 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	29,831	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	4,770	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	111,684	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	61,263	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	721,625	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	757,365	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	316,065	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	100,459	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	775,460	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	112,200	0	0	0	74.00
76.00	03950	OUTSIDE LOA SERVICES	0.000000	5,000	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0.000000	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		2,995,722	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D Part V Date/Time Prepared: 9/28/2021 10:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.274627	0	0	0	0	54.00
57.00	05700	CT SCAN	0.274630	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.239035	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.977852	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1.024002	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.464724	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.564530	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.613764	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.483507	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.767902	0	0	0	0	74.00
76.00	03950	OUTSIDE LOA SERVICES	4.139867	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0.000000	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	0	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	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D Part V Date/Time Prepared: 9/28/2021 10:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
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
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OUTSIDE LOA SERVICES	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
91.01	04951	OUTPATIENT THERAPY	0	0		91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D Part I Date/Time Prepared: 9/28/2021 10:35 am

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	2,580,573	0	2,580,573	5,229	493.51	30.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	2,580,573		2,580,573	5,229		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	7	3,455		30.00
44.00	SKILLED NURSING FACILITY	0	0		44.00
200.00	Total (lines 30 through 199)	7	3,455		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D Part II Date/Time Prepared: 9/28/2021 10:35 am

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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	427	53,895	0.007923	0	0	54.00
57.00	05700	CT SCAN	124	15,621	0.007938	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	20,248	198,251	0.102133	83	8	60.00
65.00	06500	RESPIRATORY THERAPY	2,919	118,839	0.024563	21	1	65.00
66.00	06600	PHYSICAL THERAPY	487,326	1,215,335	0.400981	1,950	782	66.00
67.00	06700	OCCUPATIONAL THERAPY	95,549	1,276,185	0.074871	1,625	122	67.00
68.00	06800	SPEECH PATHOLOGY	40,967	563,265	0.072731	1,040	76	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	122,032	143,508	0.850350	47	40	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	118,373	1,426,567	0.082978	2,352	195	73.00
74.00	07400	RENAL DIALYSIS	4,024	216,150	0.018617	0	0	74.00
76.00	03950	OUTSIDE LOA SERVICES	1,375	15,000	0.091667	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	1	0	0.000000	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	893,365	5,242,616		7,118	1,224	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D Part III Date/Time Prepared: 9/28/2021 10:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	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
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
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	5,229	0.00	7	30.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	5,229		7	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
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D Part IV | Date/Time Prepared: 9/28/2021 10:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
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
76.00	03950	OUTSIDE LOA SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D Part IV Date/Time Prepared: 9/28/2021 10:35 am

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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	53,895	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	15,621	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	198,251	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	118,839	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,215,335	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,276,185	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	563,265	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	143,508	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,426,567	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	216,150	0.000000	74.00
76.00	03950	OUTSIDE LOA SERVICES	0	0	0	15,000	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0.000000	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	5,242,616		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D Part IV | Date/Time Prepared: 9/28/2021 10:35 am

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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	83	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	21	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,950	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,625	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,040	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	47	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,352	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	OUTSIDE LOA SERVICES	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0.000000	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		7,118	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D Part V Date/Time Prepared: 9/28/2021 10:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.274627	0	0	0	0	54.00
57.00	05700	CT SCAN	0.274630	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.239035	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.977852	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1.024002	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.464724	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.564530	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.613764	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.483507	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.767902	0	0	0	0	74.00
76.00	03950	OUTSIDE LOA SERVICES	4.139867	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0.000000	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	0	0	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	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D Part V Date/Time Prepared: 9/28/2021 10:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
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
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OUTSIDE LOA SERVICES	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
91.01	04951	OUTPATIENT THERAPY	0	0		91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D-1 | Date/Time Prepared: 9/28/2021 10:35 am

Title XVIII | 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)	5,229	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,229	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,229	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	3,069	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,071,461	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,071,461	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)	7,071,461	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,352.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,150,362	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	4,150,362	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D-1 | Date/Time Prepared: 9/28/2021 10:35 am

Title XVIII | 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,109,817	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,260,179	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)	1,514,582	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	534,555	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,049,137	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,211,042	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D-1 | Date/Time Prepared: 9/28/2021 10:35 am

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	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	2,580,573	7,071,461	0.364928	0	0	90.00
91.00	Nursing School cost	0	7,071,461	0.000000	0	0	91.00
92.00	Allied health cost	0	7,071,461	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,071,461	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D-1 | Date/Time Prepared: 9/28/2021 10:35 am

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)	5,229	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,229	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,229	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	7	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,071,461	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,071,461	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)	7,071,461	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,352.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	9,466	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)	9,466	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D-1 | Date/Time Prepared: 9/28/2021 10:35 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	4,640	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	14,106	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)	3,455	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,224	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	4,679	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	9,427	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D-1 | Date/Time Prepared: 9/28/2021 10:35 am

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	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	2,580,573	7,071,461	0.364928	0	0	90.00
91.00	Nursing School cost	0	7,071,461	0.000000	0	0	91.00
92.00	Allied health cost	0	7,071,461	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,071,461	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D-3 | Date/Time Prepared: 9/28/2021 10:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,069,000		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.274627	29,831	8,192	54.00
57.00	05700	CT SCAN	0.274630	4,770	1,310	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.239035	111,684	26,696	60.00
65.00	06500	RESPIRATORY THERAPY	0.977852	61,263	59,906	65.00
66.00	06600	PHYSICAL THERAPY	1.024002	721,625	738,945	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.464724	757,365	351,966	67.00
68.00	06800	SPEECH PATHOLOGY	0.564530	316,065	178,428	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.613764	100,459	262,576	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.483507	775,460	374,940	73.00
74.00	07400	RENAL DIALYSIS	0.767902	112,200	86,159	74.00
76.00	03950	OUTSIDE LOA SERVICES	4.139867	5,000	20,699	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.000000	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0.000000	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,995,722	2,109,817	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)		2,995,722		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet D-3 | Date/Time Prepared: 9/28/2021 10:35 am

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		7,000		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.274627	0	0	54.00
57.00	05700	CT SCAN	0.274630	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.239035	83	20	60.00
65.00	06500	RESPIRATORY THERAPY	0.977852	21	21	65.00
66.00	06600	PHYSICAL THERAPY	1.024002	1,950	1,997	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.464724	1,625	755	67.00
68.00	06800	SPEECH PATHOLOGY	0.564530	1,040	587	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.613764	47	123	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.483507	2,352	1,137	73.00
74.00	07400	RENAL DIALYSIS	0.767902	0	0	74.00
76.00	03950	OUTSIDE LOA SERVICES	4.139867	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.000000	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0.000000	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,118	4,640	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)		7,118		202.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet E-1 Part I | Date/Time Prepared: 9/28/2021 10:35 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,959,424		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)		4,959,424		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		122,328		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		5,081,752		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	Provider CCN: 15-3047	Period: From 05/28/2020 To 04/30/2021	Worksheet E-3 Part III Date/Time Prepared: 9/28/2021 10:35 am
	Title XVIII	Hospital	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	5,082,202	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	120,448	3.00
4.00	Outlier Payments	0	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	15.470414	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	5,202,650	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	5,202,650	17.00
18.00	Primary payer payments	20,511	18.00
19.00	Subtotal (line 17 less line 18).	5,182,139	19.00
20.00	Deductibles	55,824	20.00
21.00	Subtotal (line 19 minus line 20)	5,126,315	21.00
22.00	Coinsurance	46,443	22.00
23.00	Subtotal (line 21 minus line 22)	5,079,872	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	2,892	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	1,880	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	2,892	26.00
27.00	Subtotal (sum of lines 23 and 25)	5,081,752	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	5,081,752	32.00
32.01	Sequestration adjustment (see instructions)	0	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	4,959,424	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	122,328	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3047	Period: From 05/28/2020 To 04/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 9/28/2021 10:35 am
	Title XIX	Hospital	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	7,000		8.00
9.00	Ancillary service charges	7,118	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	14,118	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	14,118	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	14,118	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	3,422	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-3,422	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet G | Date/Time Prepared: 9/28/2021 10:35 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	241,994	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,010,354	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-911,260	0	0	0	6.00
7.00	Inventory	78,395	0	0	0	7.00
8.00	Prepaid expenses	174,151	0	0	0	8.00
9.00	Other current assets	-12,927	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)	2,580,707	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	5,414	0	0	0	15.00
16.00	Accumulated depreciation	-351	0	0	0	16.00
17.00	Leasehold improvements	104,469	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	1,043,032	0	0	0	19.00
20.00	Accumulated depreciation	-119,428	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,071,614	0	0	0	23.00
24.00	Accumulated depreciation	-279,396	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)	1,825,354	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	9,269,771	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,269,771	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	13,675,832	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	275,996	0	0	0	37.00
38.00	Salaries, wages, and fees payable	291,783	0	0	0	38.00
39.00	Payroll taxes payable	222,226	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	16,484,454	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	17,274,459	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	684,017	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	684,017	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,958,476	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-4,282,644				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)	-4,282,644	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	13,675,832	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet G-1 | Date/Time Prepared: 9/28/2021 10:35 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,583,210				2.00
3.00	Total (sum of line 1 and line 2)		-2,583,210		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-2,583,210		0		11.00
12.00	INTERCOMPANY ADJUSTMENT	1,699,434		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)		1,699,434		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-4,282,644		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	INTERCOMPANY ADJUSTMENT		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: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet G-2 Parts I & II | Date/Time Prepared: 9/28/2021 10:35 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,229,000		5,229,000	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	5,229,000		5,229,000	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				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)	5,229,000		5,229,000	17.00
18.00	Ancillary services	5,242,616	0	5,242,616	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	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 (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,471,616	0	10,471,616	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		10,633,076		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)		10,633,076		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-3047 | Period: From 05/28/2020 To 04/30/2021 | Worksheet G-3 | Date/Time Prepared: 9/28/2021 10:35 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	10,471,616	1.00
2.00	Less contractual allowances and discounts on patients' accounts	2,437,552	2.00
3.00	Net patient revenues (line 1 minus line 2)	8,034,064	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	10,633,076	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,599,012	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	198	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	7,095	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	34	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	MISC INC, TRANSPORT	8,475	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	15,802	25.00
26.00	Total (line 5 plus line 25)	-2,583,210	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)	-2,583,210	29.00