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: 15-1304	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/23/2022 12:28 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/23/2022 Time: 12:28 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR Of PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RUSH MEMORIAL HOSPITAL (15-1304) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Brad Smith		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Brad Smith			2
3	Signatory Title	CEO/PRESIDENT			3
4	Date	(Dated when report is electronica			4

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	219,759	-1,343,161	0	75,681	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	23,524	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		275,127		0	10.00
200.00	Total	0	243,283	-1,068,034	0	75,681	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: 15-1304	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/23/2022 12:28 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1300 NORTH MAIN STREET	PO Box:			1.00
2.00	City: RUSHVILLE	State: IN	Zip Code: 46173-	County: RUSH	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	RUSH MEMORIAL HOSPITAL	151304	99915	1	08/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	RUSH SWING BEDS	15Z304	99915		08/01/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	RMH HEALTHCARE ASSOC	158539	99915		06/12/2019	N	O	O	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2021	12/31/2021	20.00
21.00	Type of Control (see instructions)	9		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2022 12:28 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2022 12:28 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2022 12:28 pm

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2022 12:28 pm

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2022 12:28 pm

				V	XIX	
				1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00
		1.00	2.00	3.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	132,593	0	0		118.01
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N			122.00
	Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2022 12:28 pm

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1304	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/23/2022 12:28 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/23/2022 12:28 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	02/24/2022	Y	02/24/2022	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/23/2022 12:28 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LANDON		HACKETT		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7929		LHACKETT@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II Date/Time Prepared: 5/23/2022 12:28 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2022 12:28 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	32,040.00	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)		25	9,125	32,040.00	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)		25	9,125	32,040.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2022 12:28 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	792	23	1,335			1.00
2.00	HMO and other (see instructions)	110	11				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	25	0	25			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	5			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	817	23	1,365			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)	817	23	1,365	0.00	258.77	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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	2,993	1,050	11,077	0.00	25.06	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	283.83	27.00
28.00	Observation Bed Days		14	564			28.00
29.00	Ambulance Trips	175					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: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2022 12:28 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	246	7	401	1.00
2.00	HMO and other (see instructions)			28	3		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	246	7	401	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/23/2022 12:28 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			201 CONRAD HARCOURT WAY		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	RUSHVILLE		IN	46173	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	05:00	08:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		RUSH				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	05:00	08:00	05:00	08:00	05:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1304
Component CCN: 15-8539

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

Worksheet S-8
Date/Time Prepared:
5/23/2022 12:28 pm

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	05:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-10 | Date/Time Prepared: 5/23/2022 12:28 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.319408	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,232,173	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	16,679,220	6.00
7.00	Medicaid cost (line 1 times line 6)	5,327,476	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	4,095,303	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,095,303	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	22,274	45,519	67,793	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	7,114	45,519	52,633	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	7,114	45,519	52,633	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,893,024	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	579,467	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	891,488	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,001,536	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,270,736	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,323,369	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,418,672	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/23/2022 12:28 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,148,668	2,148,668	0	2,148,668	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	451,202	5,116,680	5,567,882	15,702	5,583,584	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,253,846	3,772,222	7,026,068	-125,618	6,900,450	5.00
7.00	00700	OPERATION OF PLANT	344,743	871,861	1,216,604	39,256	1,255,860	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	106,652	106,652	0	106,652	8.00
9.00	00900	HOUSEKEEPING	631,543	219,736	851,279	39,256	890,535	9.00
10.00	01000	DIETARY	330,083	117,254	447,337	-281,686	165,651	10.00
11.00	01100	CAFETERIA	0	0	0	313,091	313,091	11.00
13.00	01300	NURSING ADMINISTRATION	149,436	8,403	157,839	0	157,839	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	108,791	130,294	239,085	19,059	258,144	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	312,909	192,013	504,922	0	504,922	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,036,814	92,298	2,129,112	-44,672	2,084,440	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,511,643	754,396	2,266,039	-770,959	1,495,080	50.00
51.00	05100	RECOVERY ROOM	0	25,282	25,282	177,048	202,330	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,240,184	699,895	1,940,079	-62,763	1,877,316	54.00
54.01	05401	ONCOLOGY	370,366	260,144	630,510	-4,869	625,641	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	849,172	1,290,175	2,139,347	-78,803	2,060,544	60.00
65.00	06500	RESPIRATORY THERAPY	163,399	36,754	200,153	-2,833	197,320	65.00
66.00	06600	PHYSICAL THERAPY	277,760	43,430	321,190	36,147	357,337	66.00
67.00	06700	OCCUPATIONAL THERAPY	194,711	2,542	197,253	36,029	233,282	67.00
68.00	06800	SPEECH PATHOLOGY	147,155	796	147,951	-72,295	75,656	68.00
69.00	06900	ELECTROCARDIOLOGY	104,637	7,345	111,982	57,684	169,666	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,029,746	1,029,746	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	634,388	634,388	0	634,388	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	591,394	4,922,646	5,514,040	-6,183	5,507,857	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,545,411	135,870	1,681,281	-37,521	1,643,760	88.00
90.00	09000	CLINIC	1,126,196	135,339	1,261,535	-37,226	1,224,309	90.00
90.01	09001	SURGICAL ASSOCIATES	64,236	554,325	618,561	7,964	626,525	90.01
90.02	09002	ORTHOPAEDICS	487,111	389,666	876,777	8,183	884,960	90.02
90.03	09003	RHEUMATOLOGY	532,745	1,441	534,186	8,643	542,829	90.03
90.04	09004	SPECIALTY CLINIC	1,124,472	307,780	1,432,252	-239,089	1,193,163	90.04
90.05	09005	PEDIATRICS	476,365	19,773	496,138	5,575	501,713	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	582,075	130,861	712,936	8,626	721,562	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	1,026,992	1,277,876	2,304,868	-37,268	2,267,600	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	110,683	24,797	135,480	-224	135,256	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,146,074	24,431,602	44,577,676	0	44,577,676	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	140,672	1,401	142,073	0	142,073	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	20,286,746	24,433,003	44,719,749	0	44,719,749	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/23/2022 12:28 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-108,453	2,040,215		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-229,083	5,354,501		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,771,440	5,129,010		5.00
7.00	00700	OPERATION OF PLANT	0	1,255,860		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	106,652		8.00
9.00	00900	HOUSEKEEPING	0	890,535		9.00
10.00	01000	DIETARY	-540	165,111		10.00
11.00	01100	CAFETERIA	-74,979	238,112		11.00
13.00	01300	NURSING ADMINISTRATION	0	157,839		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	258,144		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	504,922		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-909,266	1,175,174		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-616,447	878,633		50.00
51.00	05100	RECOVERY ROOM	0	202,330		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-713,675	1,163,641		54.00
54.01	05401	ONCOLOGY	-223,350	402,291		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	0	2,060,544		60.00
65.00	06500	RESPIRATORY THERAPY	0	197,320		65.00
66.00	06600	PHYSICAL THERAPY	0	357,337		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	233,282		67.00
68.00	06800	SPEECH PATHOLOGY	0	75,656		68.00
69.00	06900	ELECTROCARDIOLOGY	0	169,666		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-7,985	1,021,761		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	634,388		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-155,228	5,352,629		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,643,760		88.00
90.00	09000	CLINIC	-626,714	597,595		90.00
90.01	09001	SURGICAL ASSOCIATES	-554,304	72,221		90.01
90.02	09002	ORTHOPAEDICS	-885,009	-49		90.02
90.03	09003	RHEUMATOLOGY	-558,620	-15,791		90.03
90.04	09004	SPECIALTY CLINIC	-948,950	244,213		90.04
90.05	09005	PEDIATRICS	-417,069	84,644		90.05
90.06	09006	WOMEN'S HEALTH	0	0		90.06
90.07	09007	PAIN MANAGEMENT	-749,843	-28,281		90.07
90.08	09008	ONCOLOGY MD	0	0		90.08
91.00	09100	EMERGENCY	0	2,267,600		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-1,980	133,276		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,552,935	35,024,741		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	FOUNDATION	0	142,073		193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0		193.02
193.03	19303	GUEST MEALS	0	0		193.03
194.00	07950	NON REIMBURSABLE	0	0		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,552,935	35,166,814		200.00

RECLASSIFICATIONS | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/23/2022 12:28 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	B - DIETARY/ CAFETERIA				
1.00	CAFETERIA	11.00	231,025	82,066	1.00
	0		231,025	82,066	
	C - MED SUPPLY RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,029,746	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	19,059	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
	0		0	1,048,805	
	E - SALARY RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	15,702	0	1.00
2.00	OPERATION OF PLANT	7.00	39,256	0	2.00
3.00	HOUSEKEEPING	9.00	39,256	0	3.00
4.00	DIETARY	10.00	31,405	0	4.00
5.00	RECOVERY ROOM	51.00	189,466	0	5.00
6.00	PHYSICAL THERAPY	66.00	36,148	0	6.00
7.00	OCCUPATIONAL THERAPY	67.00	36,148	0	7.00
	0		387,381	0	
	G - PHYSICIAN PRACTICE ADMIN RECLASS				
1.00	CLINIC	90.00	6,013	0	1.00
2.00	SURGICAL ASSOCIATES	90.01	8,643	0	2.00
3.00	ORTHOPAEDICS	90.02	8,643	0	3.00
4.00	RHEUMATOLOGY	90.03	8,643	0	4.00
5.00	SPECIALTY CLINIC	90.04	17,287	0	5.00
6.00	PEDIATRICS	90.05	8,643	0	6.00
7.00	PAIN MANAGEMENT	90.07	8,643	0	7.00
	0		66,515	0	
	H - RECLASS RHC EXPENSE				
1.00	RURAL HEALTH CLINIC	88.00	30,050	0	1.00
	TOTALS		30,050	0	
	I - ECHO EXPENSE RECLASS				
1.00	ELECTROCARDIOLOGY	69.00	0	57,882	1.00
	TOTALS		0	57,882	
500.00	Grand Total: Increases		714,971	1,188,753	500.00

RECLASSIFICATIONS | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/23/2022 12:28 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	B - DIETARY/ CAFETERIA						
1.00	DIETARY	10.00	231,025	82,066	0		1.00
	0		231,025	82,066			
	C - MED SUPPLY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	14,622	0		1.00
2.00	OPERATING ROOM	50.00	0	581,491	0		2.00
3.00	RECOVERY ROOM	51.00	0	12,418	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,881	0		4.00
5.00	ONCOLOGY	54.01	0	4,869	0		5.00
6.00	LABORATORY	60.00	0	78,803	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	2,833	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	1	0		8.00
9.00	OCCUPATIONAL THERAPY	67.00	0	119	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	198	0		10.00
11.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,183	0		11.00
12.00	RURAL HEALTH CLINIC	88.00	0	1,056	0		12.00
13.00	CLINIC	90.00	0	43,239	0		13.00
14.00	SURGICAL ASSOCIATES	90.01	0	679	0		14.00
15.00	ORTHOPAEDICS	90.02	0	460	0		15.00
16.00	SPECIALTY CLINIC	90.04	0	256,376	0		16.00
17.00	PEDIATRICS	90.05	0	3,068	0		17.00
18.00	PAIN MANAGEMENT	90.07	0	17	0		18.00
19.00	EMERGENCY	91.00	0	37,268	0		19.00
20.00	AMBULANCE SERVICES	95.00	0	224	0		20.00
	0		0	1,048,805			
	E - SALARY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	125,618	0	0		1.00
2.00	OPERATING ROOM	50.00	189,468	0	0		2.00
3.00	SPEECH PATHOLOGY	68.00	72,295	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	0		387,381	0			
	G - PHYSICIAN PRACTICE ADMIN RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	66,515	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	0		66,515	0			
	H - RECLASS RHC EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	30,050	0	0		1.00
	TOTALS		30,050	0			
	I - ECHO EXPENSE RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	57,882	0		1.00
	TOTALS		0	57,882			
500.00	Grand Total: Decreases		714,971	1,188,753			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I | Date/Time Prepared: 5/23/2022 12:28 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	188,708	0	0	0	0	1.00
2.00	Land Improvements	486,548	62,884	0	62,884	0	2.00
3.00	Buildings and Fixtures	19,120,333	2,978,831	0	2,978,831	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,071,057	0	0	0	428,077	5.00
6.00	Movable Equipment	18,331,669	1,307,445	0	1,307,445	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	42,198,315	4,349,160	0	4,349,160	428,077	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	42,198,315	4,349,160	0	4,349,160	428,077	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	188,708	0	1.00
2.00	Land Improvements	549,432	0	2.00
3.00	Buildings and Fixtures	22,099,164	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	3,642,980	0	5.00
6.00	Movable Equipment	19,639,114	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	46,119,398	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	46,119,398	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II | Date/Time Prepared: 5/23/2022 12:28 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,751,562	0	129,241	267,865	0	1.00
3.00	Total (sum of lines 1-2)	1,751,562	0	129,241	267,865	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,148,668		1.00
3.00	Total (sum of lines 1-2)	0	2,148,668		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III Date/Time Prepared: 5/23/2022 12:28 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	46,119,398	0	46,119,398	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	46,119,398	0	46,119,398	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,750,700	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,750,700	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	21,650	267,865	0	0	2,040,215	1.00
3.00	Total (sum of lines 1-2)	21,650	267,865	0	0	2,040,215	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/23/2022 12:28 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-7,061,551			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/23/2022 12:28 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-862	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	CAFETERIA	B	-74,979	CAFETERIA	11.00	0	33.00
33.01	JAIL MEALS	B	0	CAFETERIA	11.00	0	33.01
33.02	VENDING MACHINES	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	SALE OF DRUGS	B	-20,011	DRUGS CHARGED TO PATIENTS	73.00	0	33.03
33.04	SALE OF SUPPLIES	B	0	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.04
33.05	SALE OF PODIATRY SUPPLIES	B	-7,985	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.05
33.06	PHYSICIAN APPLICATION FEES	B	-315	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	NSF FEES	B	-546	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	MEDICAL RECORDS TRANSCRIPTION FEES	B	0	MEDICAL RECORDS & LIBRARY	16.00	0	33.08
33.09	COPIER FEES	B	-2,688	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ATHLETIC TRAINER - SCHOOL REV	B	-9,025	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OCCUPATIONAL HEALTH	B	-81,959	CLINIC	90.00	0	33.11
33.12	SALE OF SCRAP	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	SHUTTLE BUS SERVICES	B	-1,980	AMBULANCE SERVICES	95.00	0	33.13
33.14	MISC. INCOME	B	-711	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	MISC. INCOME	B	-57,456	RHEUMATOLOGY	90.03	0	33.15
33.16	INTEREST INCOME	B	-107,591	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.16
33.17	TELEPHONE SALARY	A	-5,887	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	TELEPHONE OTHER	A	-1,329	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	TELEPHONE BENEFITS	A	-935	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	ADVERTISING	A	-228,537	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	IHA & AHA LOBBYING	A	-4,345	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	REBATES	B	-21,625	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	REBATES	B	0	OPERATION OF PLANT	7.00	0	33.23
33.24	REBATES	B	0	HOUSEKEEPING	9.00	0	33.24
33.25	REBATES	B	-540	DIETARY	10.00	0	33.25
33.26	REBATES	B	0	NURSING ADMINISTRATION	13.00	0	33.26
33.27	REBATES	B	-2,281	OPERATING ROOM	50.00	0	33.27
33.28	REBATES	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	33.28
33.29	REBATES	B	0	LABORATORY	60.00	0	33.29
33.30	REBATES	B	0	ELECTROCARDIOLOGY	69.00	0	33.30
33.31	REBATES	B	-135,217	DRUGS CHARGED TO PATIENTS	73.00	0	33.31
33.32	HAF EXPENSE	A	-1,698,812	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	PHYSICIAN RECRUITMENTS	A	-20,995	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	BAD DEBTS	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	MISC. INCOME	A	0	OPERATION OF PLANT	7.00	0	33.35
33.36	MISC. INCOME	A	0	ADULTS & PEDIATRICS	30.00	0	33.36
33.37	ADVERTISING	A	-4,773	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	REBATES	A	0	EMERGENCY	91.00	0	33.38
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,552,935				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 5/23/2022 12:28 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	952,261	909,266	42,995	0	0	1.00
2.00	50.00	OPERATING ROOM	619,982	614,166	5,816	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	728,573	713,675	14,898	0	0	3.00
4.00	54.01	ONCOLOGY	223,350	223,350	0	0	0	4.00
5.00	60.00	LABORATORY	38,400	0	38,400	0	0	5.00
6.00	90.00	CLINIC	560,397	544,755	15,642	0	0	6.00
7.00	90.01	SURGICAL ASSOCIATES	560,236	554,304	5,932	0	0	7.00
8.00	90.02	ORTHOPAEDICS	903,729	885,009	18,720	0	0	8.00
9.00	90.03	RHEUMATOLOGY	535,900	501,164	34,736	0	0	9.00
10.00	90.04	SPECIALTY CLINIC	967,671	948,950	18,721	0	0	10.00
11.00	90.05	PEDIATRICS	443,332	417,069	26,263	0	0	11.00
12.00	90.07	PAIN MANAGEMENT	761,718	749,843	11,875	0	0	12.00
13.00	91.00	EMERGENCY	1,148,050	0	1,148,050	0	0	13.00
200.00			8,443,599	7,061,551	1,382,048		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	54.01	ONCOLOGY	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.01	SURGICAL ASSOCIATES	0	0	0	0	0	7.00
8.00	90.02	ORTHOPAEDICS	0	0	0	0	0	8.00
9.00	90.03	RHEUMATOLOGY	0	0	0	0	0	9.00
10.00	90.04	SPECIALTY CLINIC	0	0	0	0	0	10.00
11.00	90.05	PEDIATRICS	0	0	0	0	0	11.00
12.00	90.07	PAIN MANAGEMENT	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	0	0	0	0	0	13.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	909,266		1.00
2.00	50.00	OPERATING ROOM	0	0	0	614,166		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	713,675		3.00
4.00	54.01	ONCOLOGY	0	0	0	223,350		4.00
5.00	60.00	LABORATORY	0	0	0	0		5.00
6.00	90.00	CLINIC	0	0	0	544,755		6.00
7.00	90.01	SURGICAL ASSOCIATES	0	0	0	554,304		7.00
8.00	90.02	ORTHOPAEDICS	0	0	0	885,009		8.00
9.00	90.03	RHEUMATOLOGY	0	0	0	501,164		9.00
10.00	90.04	SPECIALTY CLINIC	0	0	0	948,950		10.00
11.00	90.05	PEDIATRICS	0	0	0	417,069		11.00
12.00	90.07	PAIN MANAGEMENT	0	0	0	749,843		12.00
13.00	91.00	EMERGENCY	0	0	0	0		13.00
200.00			0	0	0	7,061,551		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/23/2022 12:28 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,040,215	2,040,215				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,354,501	77,542	5,432,043			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,129,010	153,317	857,355	6,139,682	6,139,682	5.00
7.00	00700	OPERATION OF PLANT	1,255,860	239,301	105,243	1,600,404	338,509	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	106,652	12,257	0	118,909	25,151	8.00
9.00	00900	HOUSEKEEPING	890,535	48,805	183,847	1,123,187	237,571	9.00
10.00	01000	DIETARY	165,111	71,702	35,756	272,569	57,652	10.00
11.00	01100	CAFETERIA	238,112	17,205	63,317	318,634	67,396	11.00
13.00	01300	NURSING ADMINISTRATION	157,839	2,269	40,956	201,064	42,528	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	258,144	45,253	29,816	333,213	70,480	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	504,922	78,900	85,759	669,581	141,626	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,175,174	153,001	549,996	1,878,171	397,261	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	878,633	127,091	362,370	1,368,094	289,372	50.00
51.00	05100	RECOVERY ROOM	202,330	10,955	51,927	265,212	56,096	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,163,641	74,864	339,898	1,578,403	333,856	54.00
54.01	05401	ONCOLOGY	402,291	72,260	101,507	576,058	121,845	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	2,060,544	52,284	232,733	2,345,561	496,121	60.00
65.00	06500	RESPIRATORY THERAPY	197,320	2,604	44,783	244,707	51,759	65.00
66.00	06600	PHYSICAL THERAPY	357,337	36,753	86,033	480,123	101,553	66.00
67.00	06700	OCCUPATIONAL THERAPY	233,282	16,052	63,272	312,606	66,121	67.00
68.00	06800	SPEECH PATHOLOGY	75,656	3,367	20,517	99,540	21,054	68.00
69.00	06900	ELECTROCARDIOLOGY	169,666	20,404	28,678	218,748	46,268	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,021,761	0	0	1,021,761	216,118	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	634,388	0	0	634,388	134,183	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,352,629	39,896	162,084	5,554,609	1,174,893	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,643,760	120,954	413,558	2,178,272	460,737	88.00
90.00	09000	CLINIC	597,595	179,282	310,306	1,087,183	229,956	90.00
90.01	09001	SURGICAL ASSOCIATES	72,221	30,801	19,974	122,996	26,015	90.01
90.02	09002	ORTHOPAEDICS	-49	19,158	135,872	154,981	32,781	90.02
90.03	09003	RHEUMATOLOGY	-15,791	42,147	148,379	174,735	36,959	90.03
90.04	09004	SPECIALTY CLINIC	244,213	59,277	312,923	616,413	130,381	90.04
90.05	09005	PEDIATRICS	84,644	62,476	132,927	280,047	59,234	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	-28,281	28,625	161,899	162,243	34,317	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	2,267,600	74,399	281,469	2,623,468	554,903	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	133,276	31,396	30,335	195,007	41,247	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,024,741	2,004,597	5,393,489	34,950,569	6,093,943	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	142,073	35,618	38,554	216,245	45,739	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	35,166,814	2,040,215	5,432,043	35,166,814	6,139,682	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/23/2022 12:28 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,938,913					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,137	159,197				8.00
9.00	00900	HOUSEKEEPING	60,272	11,174	1,432,204			9.00
10.00	01000	DIETARY	88,547	4,581	68,053	491,402		10.00
11.00	01100	CAFETERIA	21,247	0	16,329	0	423,606	11.00
13.00	01300	NURSING ADMINISTRATION	2,802	0	2,154	0	2,157	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	55,884	0	42,950	0	6,450	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	97,436	0	74,885	0	16,719	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	188,946	103,805	145,215	491,402	46,662	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	156,950	10,419	120,624	0	26,729	50.00
51.00	05100	RECOVERY ROOM	13,529	0	10,398	0	8,823	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	92,452	6,732	71,054	0	30,396	54.00
54.01	05401	ONCOLOGY	89,236	0	68,583	0	13,785	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	64,567	0	49,623	0	32,122	60.00
65.00	06500	RESPIRATORY THERAPY	3,216	1,341	2,471	0	5,242	65.00
66.00	06600	PHYSICAL THERAPY	45,387	3,134	34,883	0	10,743	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,823	1,441	15,235	0	6,493	67.00
68.00	06800	SPEECH PATHOLOGY	4,157	61	3,195	0	2,136	68.00
69.00	06900	ELECTROCARDIOLOGY	25,197	0	19,366	0	4,293	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,269	0	37,866	0	14,497	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	149,370	0	114,799	0	54,064	88.00
90.00	09000	CLINIC	221,403	0	170,158	0	40,039	90.00
90.01	09001	SURGICAL ASSOCIATES	38,037	0	29,234	0	4,120	90.01
90.02	09002	ORTHOPAEDICS	23,658	0	18,183	0	4,703	90.02
90.03	09003	RHEUMATOLOGY	52,049	0	40,002	0	7,594	90.03
90.04	09004	SPECIALTY CLINIC	73,203	0	56,261	0	24,421	90.04
90.05	09005	PEDIATRICS	77,154	0	59,297	0	11,498	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	35,350	0	27,168	0	8,047	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	91,877	16,509	70,613	0	35,919	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	38,772	0	29,799	0	1,963	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,894,927	159,197	1,398,398	491,402	419,615	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	43,986	0	33,806	0	3,991	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,938,913	159,197	1,432,204	491,402	423,606	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/23/2022 12:28 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	250,705					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	508,977				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	485	1,000,732			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,777	8,461	429,975	3,738,675	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,952	120,719	0	2,120,859	0	50.00
51.00	05100	RECOVERY ROOM	9,219	2,217	94,561	460,055	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,778	9,529	114,491	2,268,691	0	54.00
54.01	05401	ONCOLOGY	14,401	3,150	0	887,058	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	33,580	120,215	0	3,141,789	0	60.00
65.00	06500	RESPIRATORY THERAPY	5,487	1,309	2,120	317,652	0	65.00
66.00	06600	PHYSICAL THERAPY	11,240	783	0	687,846	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,777	431	0	428,927	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,233	124	0	132,500	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,477	1,576	0	319,925	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	81,060	0	1,318,939	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	114,719	0	883,290	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,164	4,201	0	6,850,499	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,969	0	2,963,211	0	88.00
90.00	09000	CLINIC	0	10,665	0	1,759,404	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	246	0	220,648	0	90.01
90.02	09002	ORTHOPAEDICS	0	82	0	234,388	0	90.02
90.03	09003	RHEUMATOLOGY	0	50	0	311,389	0	90.03
90.04	09004	SPECIALTY CLINIC	0	6,798	0	907,477	0	90.04
90.05	09005	PEDIATRICS	0	2,059	0	489,289	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	307	0	267,432	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	37,558	13,570	359,585	3,804,002	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,062	252	0	309,102	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	250,705	508,977	1,000,732	34,823,047	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	0	0	343,767	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	250,705	508,977	1,000,732	35,166,814	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/23/2022 12:28 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	3,738,675		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,120,859		50.00
51.00	05100	RECOVERY ROOM	460,055		51.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,268,691		54.00
54.01	05401	ONCOLOGY	887,058		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		55.00
60.00	06000	LABORATORY	3,141,789		60.00
65.00	06500	RESPIRATORY THERAPY	317,652		65.00
66.00	06600	PHYSICAL THERAPY	687,846		66.00
67.00	06700	OCCUPATIONAL THERAPY	428,927		67.00
68.00	06800	SPEECH PATHOLOGY	132,500		68.00
69.00	06900	ELECTROCARDIOLOGY	319,925		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,318,939		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	883,290		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,850,499		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	2,963,211		88.00
90.00	09000	CLINIC	1,759,404		90.00
90.01	09001	SURGICAL ASSOCIATES	220,648		90.01
90.02	09002	ORTHOPAEDICS	234,388		90.02
90.03	09003	RHEUMATOLOGY	311,389		90.03
90.04	09004	SPECIALTY CLINIC	907,477		90.04
90.05	09005	PEDIATRICS	489,289		90.05
90.06	09006	WOMEN'S HEALTH	0		90.06
90.07	09007	PAIN MANAGEMENT	267,432		90.07
90.08	09008	ONCOLOGY MD	0		90.08
91.00	09100	EMERGENCY	3,804,002		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	309,102		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,823,047		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
193.01	19301	FOUNDATION	343,767		193.01
193.02	19302	OCCUPATIONAL MEDICINE	0		193.02
193.03	19303	GUEST MEALS	0		193.03
194.00	07950	NON REIMBURSABLE	0		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	35,166,814		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/23/2022 12:28 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	77,542	77,542	77,542		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	153,317	153,317	12,245	165,562	5.00
7.00	00700	OPERATION OF PLANT	0	239,301	239,301	1,502	9,129	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,257	12,257	0	678	8.00
9.00	00900	HOUSEKEEPING	0	48,805	48,805	2,624	6,407	9.00
10.00	01000	DIETARY	0	71,702	71,702	510	1,555	10.00
11.00	01100	CAFETERIA	0	17,205	17,205	904	1,817	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,269	2,269	585	1,147	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	45,253	45,253	426	1,901	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	78,900	78,900	1,224	3,819	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	153,001	153,001	7,850	10,713	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	127,091	127,091	5,172	7,804	50.00
51.00	05100	RECOVERY ROOM	0	10,955	10,955	741	1,513	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	74,864	74,864	4,852	9,003	54.00
54.01	05401	ONCOLOGY	0	72,260	72,260	1,449	3,286	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	52,284	52,284	3,322	13,379	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,604	2,604	639	1,396	65.00
66.00	06600	PHYSICAL THERAPY	0	36,753	36,753	1,228	2,739	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	16,052	16,052	903	1,783	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,367	3,367	293	568	68.00
69.00	06900	ELECTROCARDIOLOGY	0	20,404	20,404	409	1,248	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5,828	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3,619	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39,896	39,896	2,314	31,674	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	120,954	120,954	5,903	12,425	88.00
90.00	09000	CLINIC	0	179,282	179,282	4,429	6,201	90.00
90.01	09001	SURGICAL ASSOCIATES	0	30,801	30,801	285	702	90.01
90.02	09002	ORTHOPAEDICS	0	19,158	19,158	1,939	884	90.02
90.03	09003	RHEUMATOLOGY	0	42,147	42,147	2,118	997	90.03
90.04	09004	SPECIALTY CLINIC	0	59,277	59,277	4,467	3,516	90.04
90.05	09005	PEDIATRICS	0	62,476	62,476	1,897	1,597	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	28,625	28,625	2,311	925	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	74,399	74,399	4,018	14,964	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	31,396	31,396	433	1,112	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,004,597	2,004,597	76,992	164,329	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	35,618	35,618	550	1,233	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,040,215	2,040,215	77,542	165,562	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/23/2022 12:28 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	249,932					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,951	14,886				8.00
9.00	00900	HOUSEKEEPING	7,769	1,045	66,650			9.00
10.00	01000	DIETARY	11,414	428	3,167	88,776		10.00
11.00	01100	CAFETERIA	2,739	0	760	0	23,425	11.00
13.00	01300	NURSING ADMINISTRATION	361	0	100	0	119	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,204	0	1,999	0	357	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,560	0	3,485	0	925	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,356	9,706	6,758	88,776	2,580	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,231	974	5,613	0	1,478	50.00
51.00	05100	RECOVERY ROOM	1,744	0	484	0	488	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,917	630	3,307	0	1,681	54.00
54.01	05401	ONCOLOGY	11,503	0	3,192	0	762	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	8,323	0	2,309	0	1,776	60.00
65.00	06500	RESPIRATORY THERAPY	415	125	115	0	290	65.00
66.00	06600	PHYSICAL THERAPY	5,851	293	1,623	0	594	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,555	135	709	0	359	67.00
68.00	06800	SPEECH PATHOLOGY	536	6	149	0	118	68.00
69.00	06900	ELECTROCARDIOLOGY	3,248	0	901	0	237	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,351	0	1,762	0	802	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	19,254	0	5,342	0	2,990	88.00
90.00	09000	CLINIC	28,539	0	7,920	0	2,214	90.00
90.01	09001	SURGICAL ASSOCIATES	4,903	0	1,360	0	228	90.01
90.02	09002	ORTHOPAEDICS	3,050	0	846	0	260	90.02
90.03	09003	RHEUMATOLOGY	6,709	0	1,862	0	420	90.03
90.04	09004	SPECIALTY CLINIC	9,436	0	2,618	0	1,350	90.04
90.05	09005	PEDIATRICS	9,945	0	2,759	0	636	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	4,557	0	1,264	0	445	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	11,843	1,544	3,286	0	1,986	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,998	0	1,387	0	109	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	244,262	14,886	65,077	88,776	23,204	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	5,670	0	1,573	0	221	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	249,932	14,886	66,650	88,776	23,425	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/23/2022 12:28 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	4,581					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	57,140				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	54	100,967			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	891	950	43,381	348,962	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	511	13,553	0	182,427	0	50.00
51.00	05100	RECOVERY ROOM	168	249	9,541	25,883	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	581	1,070	11,551	119,456	0	54.00
54.01	05401	ONCOLOGY	263	354	0	93,069	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	614	13,496	0	95,503	0	60.00
65.00	06500	RESPIRATORY THERAPY	100	147	214	6,045	0	65.00
66.00	06600	PHYSICAL THERAPY	205	88	0	49,374	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	124	48	0	22,668	0	67.00
68.00	06800	SPEECH PATHOLOGY	41	14	0	5,092	0	68.00
69.00	06900	ELECTROCARDIOLOGY	82	177	0	26,706	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,100	0	14,928	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	12,879	0	16,498	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	277	472	0	83,548	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	670	0	167,538	0	88.00
90.00	09000	CLINIC	0	1,197	0	229,782	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	28	0	38,307	0	90.01
90.02	09002	ORTHOPAEDICS	0	9	0	26,146	0	90.02
90.03	09003	RHEUMATOLOGY	0	6	0	54,259	0	90.03
90.04	09004	SPECIALTY CLINIC	0	763	0	81,427	0	90.04
90.05	09005	PEDIATRICS	0	231	0	79,541	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	34	0	38,161	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	686	1,523	36,280	150,529	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	38	28	0	39,501	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,581	57,140	100,967	1,995,350	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	0	0	44,865	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,581	57,140	100,967	2,040,215	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/23/2022 12:28 pm

		Cost Center Description	Total
			26.00
		GENERAL SERVICE COST CENTERS	
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	
5.00	00500	ADMINISTRATIVE & GENERAL	
7.00	00700	OPERATION OF PLANT	
8.00	00800	LAUNDRY & LINEN SERVICE	
9.00	00900	HOUSEKEEPING	
10.00	01000	DIETARY	
11.00	01100	CAFETERIA	
13.00	01300	NURSING ADMINISTRATION	
14.00	01400	CENTRAL SERVICES & SUPPLY	
16.00	01600	MEDICAL RECORDS & LIBRARY	
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	348,962
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	182,427
51.00	05100	RECOVERY ROOM	25,883
53.00	05300	ANESTHESIOLOGY	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	119,456
54.01	05401	ONCOLOGY	93,069
55.00	05500	RADIOLOGY-THERAPEUTIC	0
60.00	06000	LABORATORY	95,503
65.00	06500	RESPIRATORY THERAPY	6,045
66.00	06600	PHYSICAL THERAPY	49,374
67.00	06700	OCCUPATIONAL THERAPY	22,668
68.00	06800	SPEECH PATHOLOGY	5,092
69.00	06900	ELECTROCARDIOLOGY	26,706
70.00	07000	ELECTROENCEPHALOGRAPHY	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,928
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,498
73.00	07300	DRUGS CHARGED TO PATIENTS	83,548
		OUTPATIENT SERVICE COST CENTERS	
88.00	08800	RURAL HEALTH CLINIC	167,538
90.00	09000	CLINIC	229,782
90.01	09001	SURGICAL ASSOCIATES	38,307
90.02	09002	ORTHOPAEDICS	26,146
90.03	09003	RHEUMATOLOGY	54,259
90.04	09004	SPECIALTY CLINIC	81,427
90.05	09005	PEDIATRICS	79,541
90.06	09006	WOMEN'S HEALTH	0
90.07	09007	PAIN MANAGEMENT	38,161
90.08	09008	ONCOLOGY MD	0
91.00	09100	EMERGENCY	150,529
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	
		OTHER REIMBURSABLE COST CENTERS	
95.00	09500	AMBULANCE SERVICES	39,501
		SPECIAL PURPOSE COST CENTERS	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,995,350
		NONREIMBURSABLE COST CENTERS	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0
193.00	19300	NONPAID WORKERS	0
193.01	19301	FOUNDATION	44,865
193.02	19302	OCCUPATIONAL MEDICINE	0
193.03	19303	GUEST MEALS	0
194.00	07950	NON REIMBURSABLE	0
200.00		Cross Foot Adjustments	0
201.00		Negative Cost Centers	0
202.00		TOTAL (sum lines 118 through 201)	2,040,215

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/23/2022 12:28 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	109,691					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,169	19,819,842				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,243	3,128,228	-6,139,682	29,027,132		5.00
7.00	00700	OPERATION OF PLANT	12,866	383,999	0	1,600,404	84,413	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	659	0	0	118,909	659	8.00
9.00	00900	HOUSEKEEPING	2,624	670,799	0	1,123,187	2,624	9.00
10.00	01000	DIETARY	3,855	130,463	0	272,569	3,855	10.00
11.00	01100	CAFETERIA	925	231,025	0	318,634	925	11.00
13.00	01300	NURSING ADMINISTRATION	122	149,436	0	201,064	122	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,433	108,791	0	333,213	2,433	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,242	312,909	0	669,581	4,242	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,226	2,006,764	0	1,878,171	8,226	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,833	1,322,175	0	1,368,094	6,833	50.00
51.00	05100	RECOVERY ROOM	589	189,466	0	265,212	589	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,025	1,240,184	0	1,578,403	4,025	54.00
54.01	05401	ONCOLOGY	3,885	370,366	0	576,058	3,885	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	2,811	849,172	0	2,345,561	2,811	60.00
65.00	06500	RESPIRATORY THERAPY	140	163,399	0	244,707	140	65.00
66.00	06600	PHYSICAL THERAPY	1,976	313,908	0	480,123	1,976	66.00
67.00	06700	OCCUPATIONAL THERAPY	863	230,859	0	312,606	863	67.00
68.00	06800	SPEECH PATHOLOGY	181	74,860	0	99,540	181	68.00
69.00	06900	ELECTROCARDIOLOGY	1,097	104,637	0	218,748	1,097	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,021,761	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	634,388	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,145	591,394	0	5,554,609	2,145	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,503	1,508,946	0	2,178,272	6,503	88.00
90.00	09000	CLINIC	9,639	1,132,209	0	1,087,183	9,639	90.00
90.01	09001	SURGICAL ASSOCIATES	1,656	72,879	0	122,996	1,656	90.01
90.02	09002	ORTHOPAEDICS	1,030	495,754	0	154,981	1,030	90.02
90.03	09003	RHEUMATOLOGY	2,266	541,388	0	174,735	2,266	90.03
90.04	09004	SPECIALTY CLINIC	3,187	1,141,759	0	616,413	3,187	90.04
90.05	09005	PEDIATRICS	3,359	485,008	0	280,047	3,359	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	1,539	590,718	0	162,243	1,539	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	4,000	1,026,992	0	2,623,468	4,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,688	110,683	0	195,007	1,688	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	107,776	19,679,170	-6,139,682	28,810,887	82,498	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	1,915	140,672	0	216,245	1,915	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,040,215	5,432,043		6,139,682	1,938,913	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.599657	0.274071		0.211515	22.969365	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		77,542		165,562	249,932	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.003912		0.005704	2.960824	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: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/23/2022 12:28 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	28,495					8.00
9.00	00900	HOUSEKEEPING	2,000	81,130				9.00
10.00	01000	DIETARY	820	3,855	100			10.00
11.00	01100	CAFETERIA	0	925	0	19,636		11.00
13.00	01300	NURSING ADMINISTRATION	0	122	0	100	231,235	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,433	0	299	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,242	0	775	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,580	8,226	100	2,163	44,989	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,865	6,833	0	1,239	25,781	50.00
51.00	05100	RECOVERY ROOM	0	589	0	409	8,503	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,205	4,025	0	1,409	29,310	54.00
54.01	05401	ONCOLOGY	0	3,885	0	639	13,283	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	2,811	0	1,489	30,972	60.00
65.00	06500	RESPIRATORY THERAPY	240	140	0	243	5,061	65.00
66.00	06600	PHYSICAL THERAPY	561	1,976	0	498	10,367	66.00
67.00	06700	OCCUPATIONAL THERAPY	258	863	0	301	6,251	67.00
68.00	06800	SPEECH PATHOLOGY	11	181	0	99	2,060	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,097	0	199	4,129	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,145	0	672	13,986	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,503	0	2,506	0	88.00
90.00	09000	CLINIC	0	9,639	0	1,856	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	1,656	0	191	0	90.01
90.02	09002	ORTHOPAEDICS	0	1,030	0	218	0	90.02
90.03	09003	RHEUMATOLOGY	0	2,266	0	352	0	90.03
90.04	09004	SPECIALTY CLINIC	0	3,187	0	1,132	0	90.04
90.05	09005	PEDIATRICS	0	3,359	0	533	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	1,539	0	373	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	2,955	4,000	0	1,665	34,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,688	0	91	1,902	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,495	79,215	100	19,451	231,235	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	1,915	0	185	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	159,197	1,432,204	491,402	423,606	250,705	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.586840	17.653199	4,914.020000	21.572927	1.084200	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,886	66,650	88,776	23,425	4,581	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.522407	0.821521	887.760000	1.192962	0.019811	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: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/23/2022 12:28 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)		
			14.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,814,614			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,683	94,400		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	46,790	40,560		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	667,573	0		50.00
51.00	05100	RECOVERY ROOM	12,258	8,920		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,697	10,800		54.00
54.01	05401	ONCOLOGY	17,417	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	664,781	0		60.00
65.00	06500	RESPIRATORY THERAPY	7,236	200		65.00
66.00	06600	PHYSICAL THERAPY	4,331	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,382	0		67.00
68.00	06800	SPEECH PATHOLOGY	686	0		68.00
69.00	06900	ELECTROCARDIOLOGY	8,714	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	448,255	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	634,388	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,233	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	33,009	0		88.00
90.00	09000	CLINIC	58,976	0		90.00
90.01	09001	SURGICAL ASSOCIATES	1,363	0		90.01
90.02	09002	ORTHOPAEDICS	454	0		90.02
90.03	09003	RHEUMATOLOGY	279	0		90.03
90.04	09004	SPECIALTY CLINIC	37,594	0		90.04
90.05	09005	PEDIATRICS	11,384	0		90.05
90.06	09006	WOMEN'S HEALTH	0	0		90.06
90.07	09007	PAIN MANAGEMENT	1,695	0		90.07
90.08	09008	ONCOLOGY MD	0	0		90.08
91.00	09100	EMERGENCY	75,041	33,920		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	1,395	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,814,614	94,400		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	FOUNDATION	0	0		193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0		193.02
193.03	19303	GUEST MEALS	0	0		193.03
194.00	07950	NON REIMBURSABLE	0	0		194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	508,977	1,000,732		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.180834	10.600975		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	57,140	100,967		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.020301	1.069566		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: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/23/2022 12:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,738,675		3,738,675	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,120,859		2,120,859	0	0	50.00
51.00	05100	RECOVERY ROOM	460,055		460,055	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,268,691		2,268,691	0	0	54.00
54.01	05401	ONCOLOGY	887,058		887,058	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
60.00	06000	LABORATORY	3,141,789		3,141,789	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	317,652	0	317,652	0	0	65.00
66.00	06600	PHYSICAL THERAPY	687,846	0	687,846	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	428,927	0	428,927	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	132,500	0	132,500	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	319,925		319,925	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,318,939		1,318,939	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	883,290		883,290	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,850,499		6,850,499	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,963,211		2,963,211	0	0	88.00
90.00	09000	CLINIC	1,759,404		1,759,404	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	220,648		220,648	0	0	90.01
90.02	09002	ORTHOPAEDICS	234,388		234,388	0	0	90.02
90.03	09003	RHEUMATOLOGY	311,389		311,389	0	0	90.03
90.04	09004	SPECIALTY CLINIC	907,477		907,477	0	0	90.04
90.05	09005	PEDIATRICS	489,289		489,289	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0		0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	267,432		267,432	0	0	90.07
90.08	09008	ONCOLOGY MD	0		0	0	0	90.08
91.00	09100	EMERGENCY	3,804,002		3,804,002	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,095,649		1,095,649		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	309,102		309,102	0	0	95.00
200.00		Subtotal (see instructions)	35,918,696	0	35,918,696	0	0	200.00
201.00		Less Observation Beds	1,095,649		1,095,649		0	201.00
202.00		Total (see instructions)	34,823,047	0	34,823,047	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/23/2022 12:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,680,254		3,680,254			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	393,045	9,340,420	9,733,465	0.217894	0.000000	50.00
51.00	05100	RECOVERY ROOM	109,437	2,732,296	2,841,733	0.161892	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	955,382	29,401,861	30,357,243	0.074733	0.000000	54.00
54.01	05401	ONCOLOGY	65	648,792	648,857	1.367109	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
60.00	06000	LABORATORY	1,142,720	12,809,815	13,952,535	0.225177	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	259,756	190,410	450,166	0.705633	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	244,082	1,982,384	2,226,466	0.308941	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	210,318	1,596,187	1,806,505	0.237435	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	82,794	395,458	478,252	0.277051	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	343,984	3,659,815	4,003,799	0.079905	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	254,369	4,828,745	5,083,114	0.259475	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	34,241	3,072,799	3,107,040	0.284287	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,053,010	18,136,085	19,189,095	0.357000	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,250,087	1,250,087			88.00
90.00	09000	CLINIC	0	479,561	479,561	3.668780	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	14,499	14,499	15.218153	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	77,071	77,071	3.041196	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	78,597	78,597	3.961843	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0	199,874	199,874	4.540245	0.000000	90.04
90.05	09005	PEDIATRICS	0	177,453	177,453	2.757288	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	265	265	0.000000	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	74,662	74,662	3.581902	0.000000	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0.000000	0.000000	90.08
91.00	09100	EMERGENCY	82,563	7,105,454	7,188,017	0.529214	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	29,069	1,028,928	1,057,997	1.035588	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	867,162	867,162	0.356452	0.000000	95.00
200.00		Subtotal (see instructions)	8,875,089	100,148,680	109,023,769			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,875,089	100,148,680	109,023,769			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/23/2022 12:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ONCOLOGY	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000		90.01
90.02	09002	ORTHOPAEDICS	0.000000		90.02
90.03	09003	RHEUMATOLOGY	0.000000		90.03
90.04	09004	SPECIALTY CLINIC	0.000000		90.04
90.05	09005	PEDIATRICS	0.000000		90.05
90.06	09006	WOMEN'S HEALTH	0.000000		90.06
90.07	09007	PAIN MANAGEMENT	0.000000		90.07
90.08	09008	ONCOLOGY MD	0.000000		90.08
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/23/2022 12:28 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,738,675		3,738,675	0	3,738,675	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,120,859		2,120,859	0	2,120,859	50.00
51.00	05100	RECOVERY ROOM	460,055		460,055	0	460,055	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,268,691		2,268,691	0	2,268,691	54.00
54.01	05401	ONCOLOGY	887,058		887,058	0	887,058	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
60.00	06000	LABORATORY	3,141,789		3,141,789	0	3,141,789	60.00
65.00	06500	RESPIRATORY THERAPY	317,652	0	317,652	0	317,652	65.00
66.00	06600	PHYSICAL THERAPY	687,846	0	687,846	0	687,846	66.00
67.00	06700	OCCUPATIONAL THERAPY	428,927	0	428,927	0	428,927	67.00
68.00	06800	SPEECH PATHOLOGY	132,500	0	132,500	0	132,500	68.00
69.00	06900	ELECTROCARDIOLOGY	319,925		319,925	0	319,925	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,318,939		1,318,939	0	1,318,939	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	883,290		883,290	0	883,290	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,850,499		6,850,499	0	6,850,499	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,963,211		2,963,211	0	2,963,211	88.00
90.00	09000	CLINIC	1,759,404		1,759,404	0	1,759,404	90.00
90.01	09001	SURGICAL ASSOCIATES	220,648		220,648	0	220,648	90.01
90.02	09002	ORTHOPAEDICS	234,388		234,388	0	234,388	90.02
90.03	09003	RHEUMATOLOGY	311,389		311,389	0	311,389	90.03
90.04	09004	SPECIALTY CLINIC	907,477		907,477	0	907,477	90.04
90.05	09005	PEDIATRICS	489,289		489,289	0	489,289	90.05
90.06	09006	WOMEN'S HEALTH	0		0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	267,432		267,432	0	267,432	90.07
90.08	09008	ONCOLOGY MD	0		0	0	0	90.08
91.00	09100	EMERGENCY	3,804,002		3,804,002	0	3,804,002	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,095,649		1,095,649		1,095,649	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	309,102		309,102	0	309,102	95.00
200.00		Subtotal (see instructions)	35,918,696	0	35,918,696	0	35,918,696	200.00
201.00		Less Observation Beds	1,095,649		1,095,649		1,095,649	201.00
202.00		Total (see instructions)	34,823,047	0	34,823,047	0	34,823,047	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/23/2022 12:28 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,680,254		3,680,254			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	393,045	9,340,420	9,733,465	0.217894	0.000000	50.00
51.00	05100	RECOVERY ROOM	109,437	2,732,296	2,841,733	0.161892	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	955,382	29,401,861	30,357,243	0.074733	0.000000	54.00
54.01	05401	ONCOLOGY	65	648,792	648,857	1.367109	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
60.00	06000	LABORATORY	1,142,720	12,809,815	13,952,535	0.225177	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	259,756	190,410	450,166	0.705633	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	244,082	1,982,384	2,226,466	0.308941	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	210,318	1,596,187	1,806,505	0.237435	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	82,794	395,458	478,252	0.277051	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	343,984	3,659,815	4,003,799	0.079905	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	254,369	4,828,745	5,083,114	0.259475	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	34,241	3,072,799	3,107,040	0.284287	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,053,010	18,136,085	19,189,095	0.357000	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,250,087	1,250,087	2.370404	0.000000	88.00
90.00	09000	CLINIC	0	479,561	479,561	3.668780	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	14,499	14,499	15.218153	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	77,071	77,071	3.041196	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	78,597	78,597	3.961843	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0	199,874	199,874	4.540245	0.000000	90.04
90.05	09005	PEDIATRICS	0	177,453	177,453	2.757288	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	265	265	0.000000	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	74,662	74,662	3.581902	0.000000	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0.000000	0.000000	90.08
91.00	09100	EMERGENCY	82,563	7,105,454	7,188,017	0.529214	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	29,069	1,028,928	1,057,997	1.035588	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	867,162	867,162	0.356452	0.000000	95.00
200.00		Subtotal (see instructions)	8,875,089	100,148,680	109,023,769			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,875,089	100,148,680	109,023,769			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/23/2022 12:28 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ONCOLOGY	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000		90.01
90.02	09002	ORTHOPAEDICS	0.000000		90.02
90.03	09003	RHEUMATOLOGY	0.000000		90.03
90.04	09004	SPECIALTY CLINIC	0.000000		90.04
90.05	09005	PEDIATRICS	0.000000		90.05
90.06	09006	WOMEN'S HEALTH	0.000000		90.06
90.07	09007	PAIN MANAGEMENT	0.000000		90.07
90.08	09008	ONCOLOGY MD	0.000000		90.08
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/23/2022 12:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	182,427	9,733,465	0.018742	145,381	2,725	50.00
51.00	05100	RECOVERY ROOM	25,883	2,841,733	0.009108	31,412	286	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	119,456	30,357,243	0.003935	448,567	1,765	54.00
54.01	05401	ONCOLOGY	93,069	648,857	0.143435	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
60.00	06000	LABORATORY	95,503	13,952,535	0.006845	564,506	3,864	60.00
65.00	06500	RESPIRATORY THERAPY	6,045	450,166	0.013428	112,579	1,512	65.00
66.00	06600	PHYSICAL THERAPY	49,374	2,226,466	0.022176	156,234	3,465	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,668	1,806,505	0.012548	131,338	1,648	67.00
68.00	06800	SPEECH PATHOLOGY	5,092	478,252	0.010647	49,787	530	68.00
69.00	06900	ELECTROCARDIOLOGY	26,706	4,003,799	0.006670	183,085	1,221	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,928	5,083,114	0.002937	40,707	120	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,498	3,107,040	0.005310	3,010	16	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	83,548	19,189,095	0.004354	514,738	2,241	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	167,538	1,250,087	0.134021	0	0	88.00
90.00	09000	CLINIC	229,782	479,561	0.479151	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	38,307	14,499	2.642044	0	0	90.01
90.02	09002	ORTHOPAEDICS	26,146	77,071	0.339246	0	0	90.02
90.03	09003	RHEUMATOLOGY	54,259	78,597	0.690344	0	0	90.03
90.04	09004	SPECIALTY CLINIC	81,427	199,874	0.407392	0	0	90.04
90.05	09005	PEDIATRICS	79,541	177,453	0.448237	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0	265	0.000000	0	0	90.06
90.07	09007	PAIN MANAGEMENT	38,161	74,662	0.511117	0	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0.000000	0	0	90.08
91.00	09100	EMERGENCY	150,529	7,188,017	0.020942	3,391	71	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	102,266	1,057,997	0.096660	1,566	151	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,709,153	104,476,353		2,386,301	19,615	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/23/2022 12:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ONCOLOGY	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	0	0	0	0	0	90.03
90.04	09004	SPECIALTY CLINIC	0	0	0	0	0	90.04
90.05	09005	PEDIATRICS	0	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	0	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/23/2022 12:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	9,733,465	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,841,733	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	30,357,243	0.000000	54.00
54.01	05401	ONCOLOGY	0	0	0	648,857	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
60.00	06000	LABORATORY	0	0	0	13,952,535	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	450,166	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,226,466	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,806,505	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	478,252	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,003,799	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,083,114	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,107,040	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	19,189,095	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,250,087	0.000000	88.00
90.00	09000	CLINIC	0	0	0	479,561	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	0	14,499	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	77,071	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	0	0	78,597	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0	0	0	199,874	0.000000	90.04
90.05	09005	PEDIATRICS	0	0	0	177,453	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	265	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	74,662	0.000000	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0.000000	90.08
91.00	09100	EMERGENCY	0	0	0	7,188,017	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,057,997	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	104,476,353		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/23/2022 12:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	145,381	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	31,412	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	448,567	0	0	0	54.00
54.01	05401	ONCOLOGY	0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.000000	564,506	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	112,579	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	156,234	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	131,338	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	49,787	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	183,085	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	40,707	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	3,010	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	514,738	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	0.000000	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	0.000000	0	0	0	0	90.03
90.04	09004	SPECIALTY CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	PEDIATRICS	0.000000	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0.000000	0	0	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	0	0	90.08
91.00	09100	EMERGENCY	0.000000	3,391	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,566	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		2,386,301	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/23/2022 12:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.217894	0	3,696,070	0	0	50.00
51.00	05100	RECOVERY ROOM	0.161892	0	566,670	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.074733	0	7,577,689	0	0	54.00
54.01	05401	ONCOLOGY	1.367109	0	303,175	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.225177	0	3,558,146	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.705633	0	40,839	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.308941	0	636,470	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.237435	0	332,748	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.277051	0	118,448	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.079905	0	1,306,179	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.259475	0	78,237	107,506	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.284287	0	651,547	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357000	0	9,738,055	2,280	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	3.668780	0	32,773	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	15.218153	0	7,686	0	0	90.01
90.02	09002	ORTHOPAEDICS	3.041196	0	52,013	0	0	90.02
90.03	09003	RHEUMATOLOGY	3.961843	0	50,372	0	0	90.03
90.04	09004	SPECIALTY CLINIC	4.540245	0	117,346	0	0	90.04
90.05	09005	PEDIATRICS	2.757288	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	3.581902	0	25,615	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	0	0	90.08
91.00	09100	EMERGENCY	0.529214	0	1,325,519	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.035588	0	375,123	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.356452		0			95.00
200.00		Subtotal (see instructions)		0	30,590,720	109,786	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	30,590,720	109,786	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/23/2022 12:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	805,351	0		50.00
51.00	05100	RECOVERY ROOM	91,739	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	566,303	0		54.00
54.01	05401	ONCOLOGY	414,473	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	801,213	0		60.00
65.00	06500	RESPIRATORY THERAPY	28,817	0		65.00
66.00	06600	PHYSICAL THERAPY	196,632	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	79,006	0		67.00
68.00	06800	SPEECH PATHOLOGY	32,816	0		68.00
69.00	06900	ELECTROCARDIOLOGY	104,370	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,301	27,895		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	185,226	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,476,486	814		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	120,237	0		90.00
90.01	09001	SURGICAL ASSOCIATES	116,967	0		90.01
90.02	09002	ORTHOPAEDICS	158,182	0		90.02
90.03	09003	RHEUMATOLOGY	199,566	0		90.03
90.04	09004	SPECIALTY CLINIC	532,780	0		90.04
90.05	09005	PEDIATRICS	0	0		90.05
90.06	09006	WOMEN'S HEALTH	0	0		90.06
90.07	09007	PAIN MANAGEMENT	91,750	0		90.07
90.08	09008	ONCOLOGY MD	0	0		90.08
91.00	09100	EMERGENCY	701,483	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	388,473	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	9,112,171	28,709		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	9,112,171	28,709		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/23/2022 12:28 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,929	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,899	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,335	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	25	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	5	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	792	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)	25	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	207.68	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)	3,738,675	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	1,038	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)	49,604	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,689,071	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)	3,689,071	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)	1,942.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,538,571	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,538,571	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/23/2022 12:28 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	583,309	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,121,880	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	48,566	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)	48,566	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)	564	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,942.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,095,649	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/23/2022 12:28 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	348,962	3,738,675	0.093338	1,095,649	102,266	90.00
91.00	Nursing Program cost	0	3,738,675	0.000000	1,095,649	0	91.00
92.00	Allied health cost	0	3,738,675	0.000000	1,095,649	0	92.00
93.00	All other Medical Education	0	3,738,675	0.000000	1,095,649	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/23/2022 12:28 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,929	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,899	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,335	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	25	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	5	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	23	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	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)	3,738,675	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)	48,580	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,690,095	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)	3,690,095	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)	1,943.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	44,693	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)	44,693	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/23/2022 12:28 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	30,988	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	75,681	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	564	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,943.18	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,095,954	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/23/2022 12:28 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	348,962	3,738,675	0.093338	1,095,954	102,294	90.00
91.00	Nursing Program cost	0	3,738,675	0.000000	1,095,954	0	91.00
92.00	Allied health cost	0	3,738,675	0.000000	1,095,954	0	92.00
93.00	All other Medical Education	0	3,738,675	0.000000	1,095,954	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/23/2022 12:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,484,209		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.217894	145,381	31,678	50.00
51.00	05100	RECOVERY ROOM	0.161892	31,412	5,085	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.074733	448,567	33,523	54.00
54.01	05401	ONCOLOGY	1.367109	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.225177	564,506	127,114	60.00
65.00	06500	RESPIRATORY THERAPY	0.705633	112,579	79,439	65.00
66.00	06600	PHYSICAL THERAPY	0.308941	156,234	48,267	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.237435	131,338	31,184	67.00
68.00	06800	SPEECH PATHOLOGY	0.277051	49,787	13,794	68.00
69.00	06900	ELECTROCARDIOLOGY	0.079905	183,085	14,629	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.259475	40,707	10,562	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.284287	3,010	856	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357000	514,738	183,761	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	3.668780	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	15.218153	0	0	90.01
90.02	09002	ORTHOPAEDICS	3.041196	0	0	90.02
90.03	09003	RHEUMATOLOGY	3.961843	0	0	90.03
90.04	09004	SPECIALTY CLINIC	4.540245	0	0	90.04
90.05	09005	PEDIATRICS	2.757288	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	90.06
90.07	09007	PAIN MANAGEMENT	3.581902	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	90.08
91.00	09100	EMERGENCY	0.529214	3,391	1,795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.035588	1,566	1,622	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,386,301	583,309	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)		2,386,301		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3

Component CCN: 15-Z304 | Date/Time Prepared: 5/23/2022 12:28 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.217894	0	0	50.00
51.00	05100	RECOVERY ROOM	0.161892	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.074733	7,708	576	54.00
54.01	05401	ONCOLOGY	1.367109	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.225177	6,139	1,382	60.00
65.00	06500	RESPIRATORY THERAPY	0.705633	17,248	12,171	65.00
66.00	06600	PHYSICAL THERAPY	0.308941	12,043	3,721	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.237435	9,235	2,193	67.00
68.00	06800	SPEECH PATHOLOGY	0.277051	6,099	1,690	68.00
69.00	06900	ELECTROCARDIOLOGY	0.079905	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.259475	1,329	345	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.284287	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357000	13,376	4,775	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	3.668780	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	15.218153	0	0	90.01
90.02	09002	ORTHOPAEDICS	3.041196	0	0	90.02
90.03	09003	RHEUMATOLOGY	3.961843	0	0	90.03
90.04	09004	SPECIALTY CLINIC	4.540245	0	0	90.04
90.05	09005	PEDIATRICS	2.757288	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	90.06
90.07	09007	PAIN MANAGEMENT	3.581902	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	90.08
91.00	09100	EMERGENCY	0.529214	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.035588	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		73,177	26,853	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)		73,177		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/23/2022 12:28 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		45,855		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.217894	0	0	50.00
51.00	05100	RECOVERY ROOM	0.161892	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.074733	35,103	2,623	54.00
54.01	05401	ONCOLOGY	1.367109	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.225177	31,196	7,025	60.00
65.00	06500	RESPIRATORY THERAPY	0.705633	11,002	7,763	65.00
66.00	06600	PHYSICAL THERAPY	0.308941	819	253	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.237435	762	181	67.00
68.00	06800	SPEECH PATHOLOGY	0.277051	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.079905	13,506	1,079	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.259475	216	56	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.284287	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357000	18,910	6,751	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	2.370404	0	0	88.00
90.00	09000	CLINIC	3.668780	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	15.218153	0	0	90.01
90.02	09002	ORTHOPAEDICS	3.041196	0	0	90.02
90.03	09003	RHEUMATOLOGY	3.961843	0	0	90.03
90.04	09004	SPECIALTY CLINIC	4.540245	0	0	90.04
90.05	09005	PEDIATRICS	2.757288	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	90.06
90.07	09007	PAIN MANAGEMENT	3.581902	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	90.08
91.00	09100	EMERGENCY	0.529214	9,933	5,257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.035588	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		121,447	30,988	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)		121,447		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1304	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/23/2022 12:28 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,140,880	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	9,140,880	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	9,232,289	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	45,592	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,366,722	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,819,975	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,819,975	30.00
31.00	Primary payer payments	988	31.00
32.00	Subtotal (line 30 minus line 31)	3,818,987	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	877,365	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	570,287	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	670,984	36.00
37.00	Subtotal (see instructions)	4,389,274	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,389,274	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	5,732,435	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-1,343,161	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I Date/Time Prepared: 5/23/2022 12:28 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,537,740		5,732,435	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	11/12/2021	112,700		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)		112,700		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)		1,650,440		5,732,435	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		219,759		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1,343,161	6.02
7.00	Total Medicare program liability (see instructions)		1,870,199		4,389,274	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/23/2022 12:28 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		52,650		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)		52,650		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		23,524		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		76,174		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1304	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/23/2022 12:28 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-2 | Date/Time Prepared: 5/23/2022 12:28 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	49,052	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	27,122	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	25	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	76,174	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	76,174	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	76,174	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	76,174	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	76,174	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	52,650	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	23,524	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1304	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prepared: 5/23/2022 12:28 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,121,880	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,121,880	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,143,099	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,143,099	19.00
20.00	Deductibles (exclude professional component)	282,080	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,861,019	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,861,019	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	14,123	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	9,180	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,429	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,870,199	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,870,199	30.00
30.01	Sequestration adjustment (see instructions)	0	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,650,440	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	219,759	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1304	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/23/2022 12:28 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	75,681		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)	75,681	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)	75,681	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	45,855		8.00
9.00	Ancillary service charges	121,447	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)	167,302	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)	167,302	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	91,621	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)	75,681	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)	75,681	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)	75,681	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)	75,681	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	75,681	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)	75,681	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	75,681	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: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/23/2022 12:28 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	17,139,096	0	0	0	1.00
2.00	Temporary investments	2,467,485	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	19,895,090	0	0	0	4.00
5.00	Other receivable	363,965	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-13,141,643	0	0	0	6.00
7.00	Inventory	1,261,855	0	0	0	7.00
8.00	Prepaid expenses	532,718	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	28,518,566	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	188,708	0	0	0	12.00
13.00	Land improvements	549,432	0	0	0	13.00
14.00	Accumulated depreciation	-680,356	0	0	0	14.00
15.00	Buildings	22,099,164	0	0	0	15.00
16.00	Accumulated depreciation	-5,216,006	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	3,642,980	0	0	0	19.00
20.00	Accumulated depreciation	-797,866	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	19,639,114	0	0	0	23.00
24.00	Accumulated depreciation	-20,734,925	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)	18,690,245	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	47,208,811	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,220,050	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,794,659	0	0	0	38.00
39.00	Payroll taxes payable	995,207	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,478,094	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	14,781,180	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	23,269,190	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,150,912	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,150,912	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,420,102	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	21,788,709				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)	21,788,709	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	47,208,811	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 | Date/Time Prepared: 5/23/2022 12:28 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		15,840,470		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,948,235				2.00
3.00	Total (sum of line 1 and line 2)		21,788,705		0		3.00
4.00	ROUNDING	4		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)		4		0		10.00
11.00	Subtotal (line 3 plus line 10)		21,788,709		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		21,788,709		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	ROUNDING		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/23/2022 12:28 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,965,136		2,965,136	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,965,136		2,965,136	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)	2,965,136		2,965,136	17.00
18.00	Ancillary services	5,356,072	109,155,131	114,511,203	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	2,158,029	2,158,029	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	867,162	867,162	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)	8,321,208	112,180,322	120,501,530	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		44,719,749		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)		44,719,749		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-3 | Date/Time Prepared: 5/23/2022 12:28 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	120,501,530	1.00
2.00	Less contractual allowances and discounts on patients' accounts	75,151,486	2.00
3.00	Net patient revenues (line 1 minus line 2)	45,350,044	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	44,719,749	4.00
5.00	Net income from service to patients (line 3 minus line 4)	630,295	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	611,379	24.00
24.01	NON-OPERATING EXPENSES/INCOME	468,343	24.01
24.02	CONTRACT PHARMACY	650,188	24.02
24.50	COVID-19 PHE Funding	3,588,030	24.50
25.00	Total other income (sum of lines 6-24)	5,317,940	25.00
26.00	Total (line 5 plus line 25)	5,948,235	26.00
27.00	OTHER	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)	5,948,235	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/23/2022 12:28 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	417,093	0	417,093	0	417,093	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	473,344	0	473,344	-36,467	436,877	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	40,338	0	40,338	0	40,338	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	22,811	0	22,811	0	22,811	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	332,933	0	332,933	0	332,933	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,286,519	0	1,286,519	-36,467	1,250,052	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	23,801	23,801	-1,055	22,746	15.00
16.00	Transportation (Health Care Staff)	0	182	182	0	182	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	23,983	23,983	-1,055	22,928	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,286,519	23,983	1,310,502	-37,522	1,272,980	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	19,524	19,524	0	19,524	29.00
30.00	Administrative Costs	258,893	92,363	351,256	0	351,256	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	258,893	111,887	370,780	0	370,780	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,545,412	135,870	1,681,282	-37,522	1,643,760	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/23/2022 12:28 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	417,093		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	436,877		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	40,338		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	22,811		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	332,933		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,250,052		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	22,746		15.00
16.00	Transportation (Health Care Staff)	0	182		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	22,928		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,272,980		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	19,524		29.00
30.00	Administrative Costs	0	351,256		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	370,780		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,643,760		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-2 | Date/Time Prepared: 5/23/2022 12:28 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.60	3,878	1	2		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	3.67	7,081	1	4		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.27	10,959		6	10,959	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.30	118			118	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.57	11,077			11,077	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,272,980	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,272,980	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					370,780	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,319,451	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,690,231	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,690,231	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,690,231	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,963,211	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1304 Component CCN: 15-8539	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/23/2022 12:28 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,963,211	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			52,321	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,910,890	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			11,077	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			11,077	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			262.79	7.00
		Calculation of Limit (1)			
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	262.79	262.79		8.00
9.00	Rate for Program covered visits (see instructions)	262.79	262.79		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	760	2,221		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	199,720	583,657		11.00
12.00	Program covered visits for mental health services (from contractor records)	2	10		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	526	2,628		13.00
14.00	Limit adjustment for mental health services (see instructions)	526	2,628		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	786,531		16.00
16.01	Total program charges (see instructions)(from contractor's records)		375,910		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		43,738		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		91,514		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		516,550		16.04
16.05	Total program cost (see instructions)	0	608,064		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		49,329		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		56,574		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		608,064		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		27,637		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		635,701		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		635,701		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		360,574		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		275,127		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/23/2022 12:28 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,250,052	1,250,052	1,250,052	1,250,052	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000465	0.001915	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	581	2,394	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	9,417	10,085	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	9,998	12,479	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,272,980	1,272,980	1,272,980	1,272,980	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,690,231	1,690,231	1,690,231	1,690,231	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.007854	0.009803	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	13,275	16,569	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	23,273	29,048	0	0	10.00
11.00	Total number of injections/infusions (from your records)	88	362	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	264.47	80.24	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	42	206	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	11,108	16,529	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		52,321			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		27,637			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1304 Component CCN: 15-8539	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/23/2022 12:28 pm

		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		360,574	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		360,574	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		275,127	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		635,701	7.00

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