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: 15-1313	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/26/2022 11:35 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/26/2022 Time: 11:35 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION 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 WOODLAWN HOSPITAL (15-1313) 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	Carrie Bowers		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	Carrie Bowers			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	59,728	-734,771	0	13,472	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	10,949	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		75,938		0	10.00
10.01	RURAL HEALTH CLINIC II	0		39,490		0	10.01
10.02	RURAL HEALTH CLINIC III	0		134,961		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		27,003		0	10.03
10.04	RURAL HEALTH CLINIC V	0		59,001		0	10.04
10.05	RURAL HEALTH CLINIC VI	0		116,645		0	10.05
200.00	Total	0	70,677	-281,733	0	13,472	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 11:35 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1400 EAST 9TH STREET	PO Box:			1.00
2.00	City: ROCHESTER	State: IN	Zip Code: 46975-	County: FULTON	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	WOODLAWN HOSPITAL	151313	99915	1	01/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WOODLAWN HOSPITAL SWINGBED	15Z313	99915		10/23/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	SHAFER MEDICAL CENTER	158551	99915		04/13/2020	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	WOODLAWN MEDICAL PROFESSIONALS	158552	99915		04/13/2020	N	O	O	15.01
15.02	Hospital-Based Health Clinic - RHC III	FULTON COUNTY MEDICAL CENTER - MAIN	158550	99915		04/13/2020	N	O	O	15.02
15.03	Hospital-Based Health Clinic - RHC IV	FULTON COUNTY MEDICAL CENTER - DUNN	158549	99915		04/13/2020	N	O	O	15.03
15.04	Hospital-Based Health Clinic - RHC V	AKRON MEDICAL CLINIC	158547	99915		04/13/2020	N	O	O	15.04
15.05	Hospital-Based Health Clinic - RHC VI	ARGOS MEDICAL CLINIC	158548	99915		04/13/2020	N	O	O	15.05
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)	8		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 11:35 am

		1.00	2.00	3.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1313	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 11:35 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 11:35 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 11:35 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 11:35 am

				V	XIX	
				1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00
		1.00	2.00	3.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	295,323	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: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 11:35 am

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1313	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 11:35 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2022 11:35 am

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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	01/28/2022	Y	01/28/2022	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 11:35 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		SMITH		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO. LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMITH@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1313	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 11:35 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 11:35 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	58,440.00	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)		21	7,665	58,440.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	9,096.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	67,536.00	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
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.04	RURAL HEALTH CLINIC V	88.04				0	26.04
26.05	RURAL HEALTH CLINIC VI	88.05				0	26.05
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: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 11:35 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	815	46	2,329			1.00
2.00	HMO and other (see instructions)	552	244				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	92	0	92			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	33			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	907	46	2,454			7.00
8.00	INTENSIVE CARE UNIT	120	0	379			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	311			13.00
14.00	Total (see instructions)	1,027	46	3,144	0.00	280.31	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	1,599	726	6,449	0.00	5.62	26.00
26.01	RURAL HEALTH CLINIC II	585	3,628	15,799	0.00	22.69	26.01
26.02	RURAL HEALTH CLINIC III	1,806	2,299	12,729	0.00	14.48	26.02
26.03	RURAL HEALTH CLINIC IV	670	570	3,120	0.00	0.86	26.03
26.04	RURAL HEALTH CLINIC V	696	595	4,398	0.00	5.81	26.04
26.05	RURAL HEALTH CLINIC VI	2,136	2,609	15,759	0.00	15.22	26.05
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	344.99	27.00
28.00	Observation Bed Days		104	783			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	22	106			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: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 11:35 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	229	14	784	1.00
2.00	HMO and other (see instructions)			129	92		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	229	14	784	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
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
26.04	RURAL HEALTH CLINIC V	0.00					26.04
26.05	RURAL HEALTH CLINIC VI	0.00					26.05
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: 15-1313 | Component CCN: 15-8551 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/26/2022 11:35 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1430 E 9TH STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ROCHESTER		IN	46975	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8551 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/26/2022 11:35 am

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8552 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/26/2022 11:35 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1400 E 9TH STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ROCHESTER		IN	46975	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1313
Component CCN: 15-8552

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

Worksheet S-8

Date/Time Prepared:
5/26/2022 11:35 am

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8550 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/26/2022 11:35 am

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			700 MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ROCHESTER		IN	46975	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

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

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

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8550 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/26/2022 11:35 am

RHC III | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8549 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/26/2022 11:35 am

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			100 EAST DUNN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	FULTON		IN	46931	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		FULTON				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8549 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/26/2022 11:35 am

RHC IV | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8547 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/26/2022 11:35 am

RHC V | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			105 SR 14 N		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	AKRON		IN	46910	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1313
Component CCN: 15-8547

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

Worksheet S-8

Date/Time Prepared:
5/26/2022 11:35 am

RHC V

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8548 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/26/2022 11:35 am

RHC VI | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			530 N MICHIGAN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ARGOS		IN	46501	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		MARSHALL				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8548 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/26/2022 11:35 am

RHC VI | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1313	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/26/2022 11:35 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.345039	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,391,730	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	24,045,132	6.00
7.00	Medicaid cost (line 1 times line 6)	8,296,508	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)	6,904,778	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)	6,904,778	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,013,186	0	1,013,186	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	349,589	0	349,589	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)	349,589	0	349,589	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)	3,592,033	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	240,872	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	370,571	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,221,462	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,241,229	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,590,818	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	8,495,596	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/26/2022 11:35 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,463,932	2,463,932	-133,980	2,329,952	1.00
1.02	00102	AKRON BUILDING		48,591	48,591	0	48,591	1.02
1.03	00103	ARGOS BUILDING		109,610	109,610	0	109,610	1.03
1.04	00101	CLAYS BUILDING		27,609	27,609	133,980	161,589	1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,076,161	4,076,161	0	4,076,161	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,582,605	5,963,962	9,546,567	154,881	9,701,448	5.00
7.00	00700	OPERATION OF PLANT	385,378	1,114,104	1,499,482	1,198,526	2,698,008	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,653	147,275	168,928	0	168,928	8.00
9.00	00900	HOUSEKEEPING	345,911	208,961	554,872	-1,135	553,737	9.00
10.00	01000	DIETARY	441,529	335,884	777,413	-488,127	289,286	10.00
11.00	01100	CAFETERIA	0	0	0	472,593	472,593	11.00
13.00	01300	NURSING ADMINISTRATION	191,751	113,549	305,300	281,385	586,685	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	406,696	4,202,083	4,608,779	-42,558	4,566,221	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	370,224	1,030,592	1,400,816	-82,094	1,318,722	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,532,742	1,276,661	3,809,403	-1,054,719	2,754,684	30.00
31.00	03100	INTENSIVE CARE UNIT	393,439	430,899	824,338	-8,792	815,546	31.00
43.00	04300	NURSERY	0	0	0	604,763	604,763	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	829,816	2,248,365	3,078,181	-124,853	2,953,328	50.00
51.00	05100	RECOVERY ROOM	450,985	220,709	671,694	0	671,694	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	173,915	173,915	52.00
53.00	05300	ANESTHESIOLOGY	0	916,228	916,228	-775	915,453	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,792,842	1,602,015	3,394,857	-325,179	3,069,678	54.00
60.00	06000	LABORATORY	1,008,348	2,116,306	3,124,654	-100,429	3,024,225	60.00
65.00	06500	RESPIRATORY THERAPY	1,044,297	476,572	1,520,869	-10,071	1,510,798	65.00
66.00	06600	PHYSICAL THERAPY	589,670	207,283	796,953	-3,280	793,673	66.00
67.00	06700	OCCUPATIONAL THERAPY	216,018	58,006	274,024	0	274,024	67.00
68.00	06800	SPEECH PATHOLOGY	102,649	24,719	127,368	0	127,368	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	828,532	828,532	0	828,532	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	802,305	694,910	1,497,215	26,606	1,523,821	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,967,926	1,574,255	4,542,181	-671,783	3,870,398	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,469,443	974,479	2,443,922	17,590	2,461,512	88.02
88.03	08803	RURAL HEALTH CLINIC IV	241,867	84,507	326,374	48,263	374,637	88.03
88.04	08804	RURAL HEALTH CLINIC V	557,918	216,296	774,214	3,494	777,708	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1,581,950	557,652	2,139,602	29,207	2,168,809	88.05
91.00	09100	EMERGENCY	1,685,260	2,483,684	4,168,944	-16,520	4,152,424	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	760,713	454,523	1,215,236	-3,748	1,211,488	93.00
93.01	04951	SHAFER MEDICAL CENTER	2,324,091	472,065	2,796,156	-25,657	2,770,499	93.01
93.02	04040	INTERNAL MEDICINE	701,189	63,539	764,728	-30,590	734,138	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,799,215	37,824,518	65,623,733	20,913	65,644,646	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	82,267	477,288	559,555	-20,913	538,642	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	27,881,482	38,301,806	66,183,288	0	66,183,288	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/26/2022 11:35 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-9,833	2,320,119		1.00
1.02	00102	AKRON BUILDING	0	48,591		1.02
1.03	00103	ARGOS BUILDING	0	109,610		1.03
1.04	00101	CLAYS BUILDING	0	161,589		1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,076,161		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,466,939	7,234,509		5.00
7.00	00700	OPERATION OF PLANT	0	2,698,008		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	168,928		8.00
9.00	00900	HOUSEKEEPING	0	553,737		9.00
10.00	01000	DIETARY	-17,788	271,498		10.00
11.00	01100	CAFETERIA	-111,354	361,239		11.00
13.00	01300	NURSING ADMINISTRATION	0	586,685		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	-3,377	4,562,844		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-19,606	1,299,116		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,754,684		30.00
31.00	03100	INTENSIVE CARE UNIT	0	815,546		31.00
43.00	04300	NURSERY	0	604,763		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,953,328		50.00
51.00	05100	RECOVERY ROOM	0	671,694		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	173,915		52.00
53.00	05300	ANESTHESIOLOGY	-854,667	60,786		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-194,324	2,875,354		54.00
60.00	06000	LABORATORY	0	3,024,225		60.00
65.00	06500	RESPIRATORY THERAPY	-100,396	1,410,402		65.00
66.00	06600	PHYSICAL THERAPY	-844	792,829		66.00
67.00	06700	OCCUPATIONAL THERAPY	-48,279	225,745		67.00
68.00	06800	SPEECH PATHOLOGY	0	127,368		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	828,532		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-252,506	1,271,315		88.00
88.01	08801	RURAL HEALTH CLINIC II	-179,265	3,691,133		88.01
88.02	08802	RURAL HEALTH CLINIC III	-18,431	2,443,081		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	374,637		88.03
88.04	08804	RURAL HEALTH CLINIC V	-5,245	772,463		88.04
88.05	08805	RURAL HEALTH CLINIC VI	-21,597	2,147,212		88.05
91.00	09100	EMERGENCY	-1,860,172	2,292,252		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	-1,049,889	161,599		93.00
93.01	04951	SHAFER MEDICAL CENTER	-2,114,269	656,230		93.01
93.02	04040	INTERNAL MEDICINE	-722,172	11,966		93.02
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-10,050,953	55,593,693		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
192.01	19201	FCMC	0	0		192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0		192.02
192.03	19203	AKRON MEDICAL CENTER	0	0		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	ADVERTISING	0	538,642		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-10,050,953	56,132,335		200.00

RECLASSIFICATIONS | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 11:35 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	273,880	198,713		1.00
	0		273,880	198,713		
	B - ADVERTISING RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	3,077	17,836		1.00
	0		3,077	17,836		
	C - DEPRECIATION RECLASS					
1.00	CLAYS BUILDING	1.04	0	133,980		1.00
	0		0	133,980		
	D - NURSERY RECLASS					
1.00	NURSERY	43.00	400,044	204,719		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	115,043	58,872		2.00
	0		515,087	263,591		
	E - NURSING SUPERVISOR RECLASS					
1.00	NURSING ADMINISTRATION	13.00	283,503	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		283,503	0		
	F - MAINTENANCE RECLASS					
1.00	OPERATION OF PLANT	7.00	0	1,198,526		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
	0		0	1,198,526		
	G - RENT RECLASS					
1.00	RURAL HEALTH CLINIC IV	88.03	0	35,299		1.00
	0		0	35,299		
	H - RHC OVERHEAD RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00		525,406		1.00
2.00	RURAL HEALTH CLINIC	88.00	26,796			2.00
3.00	RURAL HEALTH CLINIC III	88.02	52,889			3.00
4.00	RURAL HEALTH CLINIC IV	88.03	12,964			4.00
5.00	RURAL HEALTH CLINIC V	88.04	18,286			5.00
6.00	RURAL HEALTH CLINIC VI	88.05	65,479			6.00
	0		176,414	525,406		
	I - ALDRIDGE CONVERSION RECLASS					
1.00	RURAL HEALTH CLINIC II	88.01	28,048	2,542		1.00
	TOTALS		28,048	2,542		
500.00	Grand Total: Increases		1,280,009	2,375,893		500.00

RECLASSIFICATIONS | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 11:35 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	273,880	198,713	0		1.00
	0		273,880	198,713			
	B - ADVERTISING RECLASS						
1.00	ADVERTISING	194.00	3,077	17,836	0		1.00
	0		3,077	17,836			
	C - DEPRECIATION RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	133,980	9		1.00
	0		0	133,980			
	D - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	515,087	263,591	0		1.00
2.00		0.00	0	0	0		2.00
	0		515,087	263,591			
	E - NURSING SUPERVISOR RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	245,050	0	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	3,215	0	0		2.00
3.00	OPERATING ROOM	50.00	4,176	0	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	31,062	0	0		4.00
	0		283,503	0			
	F - MAINTENANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	391,438	0		1.00
2.00	HOUSEKEEPING	9.00	0	1,135	0		2.00
3.00	DIETARY	10.00	0	15,534	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	2,118	0		4.00
5.00	PHARMACY	15.00	0	42,558	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	82,094	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	30,991	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	5,577	0		8.00
9.00	OPERATING ROOM	50.00	0	120,677	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	775	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	294,117	0		11.00
12.00	LABORATORY	60.00	0	100,429	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	10,071	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	3,280	0		14.00
15.00	RURAL HEALTH CLINIC	88.00	0	190	0		15.00
16.00	RURAL HEALTH CLINIC II	88.01	0	553	0		16.00
17.00	RURAL HEALTH CLINIC V	88.04	0	14,792	0		17.00
18.00	RURAL HEALTH CLINIC VI	88.05	0	36,272	0		18.00
19.00	EMERGENCY	91.00	0	16,520	0		19.00
20.00	WOODLAWN MEDICAL PROFESSIONALS	93.00	0	3,748	0		20.00
21.00	SHAFER MEDICAL CENTER	93.01	0	25,657	0		21.00
	0		0	1,198,526			
	G - RENT RECLASS						
1.00	RURAL HEALTH CLINIC III	88.02	0	35,299	0		1.00
	0		0	35,299			
	H - RHC OVERHEAD RECLASS						
1.00	RURAL HEALTH CLINIC II	88.01	176,414	525,406	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
	0		176,414	525,406			
	I - ALDRIDGE CONVERSION RECLASS						
1.00	INTERNAL MEDICINE	93.02	28,048	2,542	0		1.00
	TOTALS		28,048	2,542			
500.00	Grand Total: Decreases		1,280,009	2,375,893			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2022 11:35 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	596,216	0	0	0	0	1.00
2.00	Land Improvements	508,688	5,094	0	5,094	0	2.00
3.00	Buildings and Fixtures	27,445,912	82,851	0	82,851	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	10,868,623	525,902	0	525,902	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	39,419,439	613,847	0	613,847	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	39,419,439	613,847	0	613,847	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	596,216	0	1.00
2.00	Land Improvements	513,782	0	2.00
3.00	Buildings and Fixtures	27,528,763	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	11,394,525	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	40,033,286	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	40,033,286	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II | Date/Time Prepared: 5/26/2022 11:35 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,381,714	0	434,350	602,564	0	1.00
1.02	AKRON BUILDING	28,466	0	0	0	0	1.02
1.03	ARGOS BUILDING	51,743	0	0	22,573	0	1.03
1.04	CLAYS BUILDING	0	0	0	0	0	1.04
3.00	Total (sum of lines 1-2)	1,461,923	0	434,350	625,137	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	45,304	2,463,932	1.00
1.02	AKRON BUILDING	20,125	48,591	1.02
1.03	ARGOS BUILDING	35,294	109,610	1.03
1.04	CLAYS BUILDING	27,609	27,609	1.04
3.00	Total (sum of lines 1-2)	128,332	2,649,742	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III Date/Time Prepared: 5/26/2022 11:35 am

	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	CAP REL COSTS-BLDG & FIXT	31,067,198	0	31,067,198	0.776034	0	1.00
1.02	AKRON BUILDING	998,991	0	998,991	0.024954	0	1.02
1.03	ARGOS BUILDING	2,140,695	0	2,140,695	0.053473	0	1.03
1.04	CLAYS BUILDING	5,826,402	0	5,826,402	0.145539	0	1.04
3.00	Total (sum of lines 1-2)	40,033,286	0	40,033,286	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	CAP REL COSTS-BLDG & FIXT	0	0	0	1,247,093	0	1.00
1.02	AKRON BUILDING	0	0	0	28,466	0	1.02
1.03	ARGOS BUILDING	0	0	0	51,743	0	1.03
1.04	CLAYS BUILDING	0	0	0	133,980	0	1.04
3.00	Total (sum of lines 1-2)	0	0	0	1,461,282	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	CAP REL COSTS-BLDG & FIXT	425,158	602,564	0	45,304	2,320,119	1.00
1.02	AKRON BUILDING	0	0	0	20,125	48,591	1.02
1.03	ARGOS BUILDING	0	22,573	0	35,294	109,610	1.03
1.04	CLAYS BUILDING	0	0	0	27,609	161,589	1.04
3.00	Total (sum of lines 1-2)	425,158	625,137	0	128,332	2,639,909	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/26/2022 11:35 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-9,192	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.02	Investment income - AKRON BUILDING (chapter 2)		0	AKRON BUILDING	1.02	0	1.02
1.03	Investment income - ARGOS BUILDING (chapter 2)		0	ARGOS BUILDING	1.03	0	1.03
1.04	Investment income - CLAYS BUILDING (chapter 2)		0	CLAYS BUILDING	1.04	0	1.04
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	-6,806,677			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-111,349	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-19,606	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-5	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.02	Depreciation - AKRON BUILDING		0	AKRON BUILDING	1.02	0	26.02
26.03	Depreciation - ARGOS BUILDING		0	ARGOS BUILDING	1.03	0	26.03
26.04	Depreciation - CLAYS BUILDING		0	CLAYS BUILDING	1.04	0	26.04
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/26/2022 11:35 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	B	-641	CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	PHYSICIAN RECRUITMENT	A	-1,504	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	HAF EXPENSE	A	-2,235,398	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	ADMIN OTHER REVENUE	B	-2,405	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	HOME MEAL PROGRAM	B	-17,788	DIETARY	10.00	0	36.00
37.00	DRUG SALES	B	-3,377	PHARMACY	15.00	0	37.00
38.00	PT - OTHER REVENUE	B	-844	PHYSICAL THERAPY	66.00	0	38.00
39.00	OCC THER OTH REV	B	-48,279	OCCUPATIONAL THERAPY	67.00	0	39.00
40.00	MISC REV -OTH REV	B	-71,133	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	STAFF RENTAL AGREEMENTS	B	-89,212	RESPIRATORY THERAPY	65.00	0	41.00
42.00	IHA & AHA LOBBYING	A	-6,098	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	PART B BILLING OFFSET	A	-12,445	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	LTC EXPENSES	A	-137,956	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	RHC OFFSETS	A	-252,506	RURAL HEALTH CLINIC	88.00	0	45.00
45.01	RHC OFFSETS	A	-179,265	RURAL HEALTH CLINIC II	88.01	0	45.01
45.02	RHC OFFSETS	A	-18,431	RURAL HEALTH CLINIC III	88.02	0	45.02
45.03	RHC OFFSETS	A	-5,245	RURAL HEALTH CLINIC V	88.04	0	45.03
45.04	RHC OFFSETS	A	-21,597	RURAL HEALTH CLINIC VI	88.05	0	45.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,050,953				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: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2022 11:35 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	53.00	ANESTHESIOLOGY	866,667	854,667	12,000	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	194,324	194,324	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	19,834	11,184	8,650	0	0	3.00
4.00	91.00	EMERGENCY	2,417,940	1,860,172	557,768	0	0	4.00
5.00	93.00	WOODLAWN MEDICAL PROFESSIONALS	1,049,889	1,049,889	0	0	0	5.00
6.00	93.01	SHAFER MEDICAL CENTER	2,114,269	2,114,269	0	0	0	6.00
7.00	93.02	INTERNAL MEDICINE	722,172	722,172	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			7,385,095	6,806,677	578,418		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	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	93.00	WOODLAWN MEDICAL PROFESSIONALS	0	0	0	0	0	5.00
6.00	93.01	SHAFER MEDICAL CENTER	0	0	0	0	0	6.00
7.00	93.02	INTERNAL MEDICINE	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	53.00	ANESTHESIOLOGY	0	0	0	854,667		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	194,324		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	11,184		3.00
4.00	91.00	EMERGENCY	0	0	0	1,860,172		4.00
5.00	93.00	WOODLAWN MEDICAL PROFESSIONALS	0	0	0	1,049,889		5.00
6.00	93.01	SHAFER MEDICAL CENTER	0	0	0	2,114,269		6.00
7.00	93.02	INTERNAL MEDICINE	0	0	0	722,172		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	6,806,677		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/26/2022 11:35 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	AKRON BUILDING	ARGOS BUILDING	CLAYS BUILDING	
			0	1.00	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,320,119	2,320,119				1.00
1.02	00102	AKRON BUILDING	48,591	0	48,591			1.02
1.03	00103	ARGOS BUILDING	109,610	0	0	109,610		1.03
1.04	00101	CLAYS BUILDING	161,589	0	0	0	161,589	1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,076,161	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,234,509	250,186	5,553	8,769	127	5.00
7.00	00700	OPERATION OF PLANT	2,698,008	225,779	3,332	9,996	36,863	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	168,928	6,842	0	0	0	8.00
9.00	00900	HOUSEKEEPING	553,737	25,856	0	0	340	9.00
10.00	01000	DIETARY	271,498	84,347	0	0	0	10.00
11.00	01100	CAFETERIA	361,239	28,841	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	586,685	58,363	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	4,562,844	29,544	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,299,116	28,137	0	0	33,633	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,754,684	321,809	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	815,546	43,868	0	0	0	31.00
43.00	04300	NURSERY	604,763	3,986	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,953,328	173,235	0	0	0	50.00
51.00	05100	RECOVERY ROOM	671,694	105,237	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	173,915	17,202	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	60,786	2,920	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,875,354	254,556	0	0	0	54.00
60.00	06000	LABORATORY	3,024,225	55,912	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,410,402	88,653	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	792,829	67,167	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	225,745	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	127,368	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	828,532	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	1,271,315	0	0	0	44,596	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,691,133	163,643	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,443,081	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	374,637	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	772,463	0	39,706	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	2,147,212	0	0	90,845	0	88.05
91.00	09100	EMERGENCY	2,292,252	133,396	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	161,599	121,991	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	656,230	0	0	0	46,030	93.01
93.02	04040	INTERNAL MEDICINE	11,966	8,654	0	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,593,693	2,300,124	48,591	109,610	161,589	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	12,470	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	538,642	7,525	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	56,132,335	2,320,119	48,591	109,610	161,589	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/26/2022 11:35 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,076,161					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	524,213	8,023,357	8,023,357			5.00
7.00	00700	OPERATION OF PLANT	56,341	3,030,319	505,381	3,535,700		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,166	178,936	29,842	10,281	219,059	8.00
9.00	00900	HOUSEKEEPING	50,571	630,504	105,152	40,227	36,185	9.00
10.00	01000	DIETARY	24,510	380,355	63,434	126,735	5,105	10.00
11.00	01100	CAFETERIA	40,040	430,120	71,733	43,334	0	11.00
13.00	01300	NURSING ADMINISTRATION	69,480	714,528	119,165	87,693	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	59,457	4,651,845	775,796	44,391	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	54,125	1,415,011	235,988	178,364	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	259,148	3,335,641	556,302	483,528	47,145	30.00
31.00	03100	INTENSIVE CARE UNIT	57,049	916,463	152,843	65,914	5,705	31.00
43.00	04300	NURSERY	58,485	667,234	111,278	5,989	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	120,705	3,247,268	541,563	260,292	12,912	50.00
51.00	05100	RECOVERY ROOM	65,932	842,863	140,568	158,122	15,915	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,819	207,936	34,679	25,847	0	52.00
53.00	05300	ANESTHESIOLOGY	0	63,706	10,625	4,388	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	257,565	3,387,475	564,946	382,478	35,734	54.00
60.00	06000	LABORATORY	147,416	3,227,553	538,275	84,009	0	60.00
65.00	06500	RESPIRATORY THERAPY	152,672	1,651,727	275,467	133,204	3,153	65.00
66.00	06600	PHYSICAL THERAPY	86,207	946,203	157,803	100,920	3,603	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,581	257,326	42,916	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,007	142,375	23,745	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	828,532	138,178	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	121,211	1,437,122	239,676	180,446	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	412,208	4,266,984	711,626	245,879	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	222,559	2,665,640	444,562	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	37,255	411,892	68,693	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	84,239	896,408	149,498	91,600	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	240,848	2,478,905	413,419	199,086	0	88.05
91.00	09100	EMERGENCY	246,378	2,672,026	445,627	200,431	53,602	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	111,213	394,803	65,843	183,296	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	339,773	1,042,033	173,785	186,243	0	93.01
93.02	04040	INTERNAL MEDICINE	98,411	119,031	19,851	13,003	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,064,584	55,562,121	7,928,259	3,535,700	219,059	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	12,470	2,080	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	11,577	557,744	93,018	0	0	194.00
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,076,161	56,132,335	8,023,357	3,535,700	219,059	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 11:35 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
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	812,068					9.00
10.00	01000	DIETARY	920	576,549				10.00
11.00	01100	CAFETERIA	10,953	0	556,140			11.00
13.00	01300	NURSING ADMINISTRATION	460	0	16,361	938,207		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	7,870	0	15,819	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,434	0	22,104	36,988	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	204,988	502,200	68,993	647,257	0	30.00
31.00	03100	INTENSIVE CARE UNIT	37,430	74,349	21,508	99,427	0	31.00
43.00	04300	NURSERY	0	0	13,679	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	103,673	0	46,537	0	0	50.00
51.00	05100	RECOVERY ROOM	62,743	0	19,314	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	3,928	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	79,457	0	78,662	0	0	54.00
60.00	06000	LABORATORY	30,912	0	51,304	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	24,908	0	43,557	0	0	65.00
66.00	06600	PHYSICAL THERAPY	17,254	0	25,029	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	6,826	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	3,332	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	33,589	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	50,357	0	59,729	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
91.00	09100	EMERGENCY	93,385	0	42,311	154,535	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	17,200	0	9,806	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	33,373	0	0	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0	0	4,903	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	811,906	576,549	553,702	938,207	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	162	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	0	2,438	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)	812,068	576,549	556,140	938,207	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 11:35 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	5,495,721					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,890,889				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	64,652	5,910,706	0	5,910,706	30.00
31.00	03100	INTENSIVE CARE UNIT	0	12,589	1,386,228	0	1,386,228	31.00
43.00	04300	NURSERY	0	3,052	801,232	0	801,232	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	223,326	4,435,571	0	4,435,571	50.00
51.00	05100	RECOVERY ROOM	0	22,788	1,262,313	0	1,262,313	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,625	276,015	0	276,015	52.00
53.00	05300	ANESTHESIOLOGY	0	27,081	105,800	0	105,800	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	408,731	4,937,483	0	4,937,483	54.00
60.00	06000	LABORATORY	0	361,774	4,293,827	0	4,293,827	60.00
65.00	06500	RESPIRATORY THERAPY	0	117,410	2,249,426	0	2,249,426	65.00
66.00	06600	PHYSICAL THERAPY	0	24,698	1,275,510	0	1,275,510	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,730	317,798	0	317,798	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,075	175,527	0	175,527	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	24,284	990,994	0	990,994	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,495,721	273,546	5,769,267	0	5,769,267	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	17,739	1,908,572	0	1,908,572	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	50,899	5,385,474	0	5,385,474	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	31,126	3,141,328	0	3,141,328	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	6,228	486,813	0	486,813	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	9,555	1,147,061	0	1,147,061	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	34,992	3,126,402	0	3,126,402	88.05
91.00	09100	EMERGENCY	0	79,023	3,740,940	0	3,740,940	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	14,434	685,382	0	685,382	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	45,652	1,481,086	0	1,481,086	93.01
93.02	04040	INTERNAL MEDICINE	0	16,880	173,668	0	173,668	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,495,721	1,890,889	55,464,423	0	55,464,423	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	162	0	162	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	14,550	0	14,550	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	0	653,200	0	653,200	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,495,721	1,890,889	56,132,335	0	56,132,335	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/26/2022 11:35 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	AKRON BUILDING	ARGOS BUILDING	CLAYS BUILDING	
			0	1.00	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	250,186	5,553	8,769	127	5.00
7.00	00700	OPERATION OF PLANT	0	225,779	3,332	9,996	36,863	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,842	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	25,856	0	0	340	9.00
10.00	01000	DIETARY	0	84,347	0	0	0	10.00
11.00	01100	CAFETERIA	0	28,841	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	58,363	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	29,544	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,137	0	0	33,633	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	321,809	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	43,868	0	0	0	31.00
43.00	04300	NURSERY	0	3,986	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	173,235	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	105,237	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,202	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,920	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	254,556	0	0	0	54.00
60.00	06000	LABORATORY	0	55,912	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	88,653	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	67,167	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	44,596	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	163,643	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	39,706	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	90,845	0	88.05
91.00	09100	EMERGENCY	0	133,396	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	121,991	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	0	46,030	93.01
93.02	04040	INTERNAL MEDICINE	0	8,654	0	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,300,124	48,591	109,610	161,589	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	12,470	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	7,525	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,320,119	48,591	109,610	161,589	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/26/2022 11:35 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	264,635	0	264,635			5.00
7.00	00700	OPERATION OF PLANT	275,970	0	16,670	292,640		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,842	0	984	851	8,677	8.00
9.00	00900	HOUSEKEEPING	26,196	0	3,468	3,329	1,433	9.00
10.00	01000	DIETARY	84,347	0	2,092	10,489	202	10.00
11.00	01100	CAFETERIA	28,841	0	2,366	3,587	0	11.00
13.00	01300	NURSING ADMINISTRATION	58,363	0	3,931	7,258	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	29,544	0	25,578	3,674	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	61,770	0	7,784	14,763	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	321,809	0	18,349	40,021	1,867	30.00
31.00	03100	INTENSIVE CARE UNIT	43,868	0	5,041	5,455	226	31.00
43.00	04300	NURSERY	3,986	0	3,670	496	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	173,235	0	17,863	21,544	511	50.00
51.00	05100	RECOVERY ROOM	105,237	0	4,637	13,087	630	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,202	0	1,144	2,139	0	52.00
53.00	05300	ANESTHESIOLOGY	2,920	0	350	363	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	254,556	0	18,634	31,657	1,415	54.00
60.00	06000	LABORATORY	55,912	0	17,755	6,953	0	60.00
65.00	06500	RESPIRATORY THERAPY	88,653	0	9,086	11,025	125	65.00
66.00	06600	PHYSICAL THERAPY	67,167	0	5,205	8,353	143	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,416	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	783	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,558	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	44,596	0	7,906	14,935	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	163,643	0	23,473	20,351	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	14,664	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	2,266	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	39,706	0	4,931	7,581	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	90,845	0	13,636	16,478	0	88.05
91.00	09100	EMERGENCY	133,396	0	14,699	16,589	2,125	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	121,991	0	2,172	15,171	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	46,030	0	5,732	15,415	0	93.01
93.02	04040	INTERNAL MEDICINE	8,654	0	655	1,076	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,619,914	0	261,498	292,640	8,677	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	12,470	0	69	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	7,525	0	3,068	0	0	194.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,639,909	0	264,635	292,640	8,677	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/26/2022 11:35 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
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	34,426					9.00
10.00	01000	DIETARY	39	97,169				10.00
11.00	01100	CAFETERIA	464	0	35,258			11.00
13.00	01300	NURSING ADMINISTRATION	19	0	1,037	70,608		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	334	0	1,003	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	103	0	1,401	2,784	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,691	84,639	4,374	48,711	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,587	12,530	1,364	7,483	0	31.00
43.00	04300	NURSERY	0	0	867	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,395	0	2,950	0	0	50.00
51.00	05100	RECOVERY ROOM	2,660	0	1,224	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	249	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,368	0	4,987	0	0	54.00
60.00	06000	LABORATORY	1,310	0	3,253	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,056	0	2,761	0	0	65.00
66.00	06600	PHYSICAL THERAPY	731	0	1,587	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	433	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	211	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,424	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,135	0	3,787	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
91.00	09100	EMERGENCY	3,959	0	2,682	11,630	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	729	0	622	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	1,415	0	0	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0	0	311	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,419	97,169	35,103	70,608	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	7	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	0	155	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)	34,426	97,169	35,258	70,608	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 11:35 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	60,133					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	88,605				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,028	531,489	0	531,489	30.00
31.00	03100	INTENSIVE CARE UNIT	0	590	78,144	0	78,144	31.00
43.00	04300	NURSERY	0	143	9,162	0	9,162	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,461	230,959	0	230,959	50.00
51.00	05100	RECOVERY ROOM	0	1,067	128,542	0	128,542	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	170	20,904	0	20,904	52.00
53.00	05300	ANESTHESIOLOGY	0	1,269	4,902	0	4,902	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,176	333,793	0	333,793	54.00
60.00	06000	LABORATORY	0	16,946	102,129	0	102,129	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,500	118,206	0	118,206	65.00
66.00	06600	PHYSICAL THERAPY	0	1,157	84,343	0	84,343	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	503	2,352	0	2,352	67.00
68.00	06800	SPEECH PATHOLOGY	0	285	1,279	0	1,279	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,138	5,696	0	5,696	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,133	12,813	72,946	0	72,946	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	831	69,692	0	69,692	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,384	215,773	0	215,773	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,458	16,122	0	16,122	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	292	2,558	0	2,558	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	448	52,666	0	52,666	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	1,639	122,598	0	122,598	88.05
91.00	09100	EMERGENCY	0	3,702	188,782	0	188,782	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	676	141,361	0	141,361	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	2,138	70,730	0	70,730	93.01
93.02	04040	INTERNAL MEDICINE	0	791	11,487	0	11,487	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	60,133	88,605	2,616,615	0	2,616,615	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	7	0	7	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	12,539	0	12,539	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	0	10,748	0	10,748	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	60,133	88,605	2,639,909	0	2,639,909	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 11:35 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	AKRON BUILDING (SQUARE FEET)	ARGOS BUILDING (SQUARE FEET)	CLAYS BUILDING (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.02	1.03	1.04	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	108,844					1.00
1.02	00102	AKRON BUILDING	0	3,500				1.02
1.03	00103	ARGOS BUILDING	0	0	7,500			1.03
1.04	00101	CLAYS BUILDING	0	0	0	20,414		1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	27,881,482	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,737	400	600	16	3,585,682	5.00
7.00	00700	OPERATION OF PLANT	10,592	240	684	4,657	385,378	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	321	0	0	0	21,653	8.00
9.00	00900	HOUSEKEEPING	1,213	0	0	43	345,911	9.00
10.00	01000	DIETARY	3,957	0	0	0	167,649	10.00
11.00	01100	CAFETERIA	1,353	0	0	0	273,880	11.00
13.00	01300	NURSING ADMINISTRATION	2,738	0	0	0	475,254	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,386	0	0	0	406,696	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,320	0	0	4,249	370,224	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,097	0	0	0	1,772,605	30.00
31.00	03100	INTENSIVE CARE UNIT	2,058	0	0	0	390,224	31.00
43.00	04300	NURSERY	187	0	0	0	400,044	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,127	0	0	0	825,640	50.00
51.00	05100	RECOVERY ROOM	4,937	0	0	0	450,985	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	807	0	0	0	115,043	52.00
53.00	05300	ANESTHESIOLOGY	137	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,942	0	0	0	1,761,780	54.00
60.00	06000	LABORATORY	2,623	0	0	0	1,008,348	60.00
65.00	06500	RESPIRATORY THERAPY	4,159	0	0	0	1,044,297	65.00
66.00	06600	PHYSICAL THERAPY	3,151	0	0	0	589,670	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	216,018	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	102,649	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,634	829,101	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,677	0	0	0	2,819,560	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	1,522,332	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	254,831	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	2,860	0	0	576,204	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	6,216	0	1,647,429	88.05
91.00	09100	EMERGENCY	6,258	0	0	0	1,685,260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	5,723	0	0	0	760,713	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	5,815	2,324,091	93.01
93.02	04040	INTERNAL MEDICINE	406	0	0	0	673,141	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	107,906	3,500	7,500	20,414	27,802,292	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	585	0	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	353	0	0	0	79,190	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)	2,320,119	48,591	109,610	161,589	4,076,161	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.316003	13.883143	14.614667	7.915597	0.146196	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 11:35 am

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	AKRON BUILDING (SQUARE FEET)	ARGOS BUILDING (SQUARE FEET)	CLAYS BUILDING (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		1.00	1.02	1.03	1.04	4.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 11:35 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	
			5A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,023,357	48,108,978				5.00
7.00	00700	OPERATION OF PLANT	0	3,030,319	110,394			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	178,936	321	1,459		8.00
9.00	00900	HOUSEKEEPING	0	630,504	1,256	241	150,135	9.00
10.00	01000	DIETARY	0	380,355	3,957	34	170	10.00
11.00	01100	CAFETERIA	0	430,120	1,353	0	2,025	11.00
13.00	01300	NURSING ADMINISTRATION	0	714,528	2,738	0	85	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	4,651,845	1,386	0	1,455	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,415,011	5,569	0	450	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,335,641	15,097	314	37,898	30.00
31.00	03100	INTENSIVE CARE UNIT	0	916,463	2,058	38	6,920	31.00
43.00	04300	NURSERY	0	667,234	187	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,247,268	8,127	86	19,167	50.00
51.00	05100	RECOVERY ROOM	0	842,863	4,937	106	11,600	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	207,936	807	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	63,706	137	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,387,475	11,942	238	14,690	54.00
60.00	06000	LABORATORY	0	3,227,553	2,623	0	5,715	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,651,727	4,159	21	4,605	65.00
66.00	06600	PHYSICAL THERAPY	0	946,203	3,151	24	3,190	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	257,326	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	142,375	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	828,532	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	1,437,122	5,634	0	6,210	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,266,984	7,677	0	9,310	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,665,640	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	411,892	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	896,408	2,860	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	2,478,905	6,216	0	0	88.05
91.00	09100	EMERGENCY	0	2,672,026	6,258	357	17,265	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	394,803	5,723	0	3,180	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	1,042,033	5,815	0	6,170	93.01
93.02	04040	INTERNAL MEDICINE	0	119,031	406	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,023,357	47,538,764	110,394	1,459	150,105	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	30	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	12,470	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	557,744	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)		8,023,357	3,535,700	219,059	812,068	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.166775	32.028009	150.143249	5.408919	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		264,635	292,640	8,677	34,426	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.005501	2.650869	5.947224	0.229300	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: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 11:35 am

		Cost Center Description	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
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	2,939					10.00
11.00	01100	CAFETERIA	0	20,531				11.00
13.00	01300	NURSING ADMINISTRATION	0	604	69,120			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	584	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	816	2,725	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,560	2,547	47,685	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	379	794	7,325	0	0	31.00
43.00	04300	NURSERY	0	505	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,718	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	713	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	145	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,904	0	0	0	54.00
60.00	06000	LABORATORY	0	1,894	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,608	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	924	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	252	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	123	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,205	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
91.00	09100	EMERGENCY	0	1,562	11,385	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	362	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0	181	0	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,939	20,441	69,120	0	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	90	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)	576,549	556,140	938,207	0	5,495,721	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	196.171827	27.087818	13.573597	0.000000	54,957.210000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	97,169	35,258	70,608	0	60,133	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	33.061926	1.717306	1.021528	0.000000	601.330000	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: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 11:35 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			16.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.02	00102	AKRON BUILDING			1.02
1.03	00103	ARGOS BUILDING			1.03
1.04	00101	CLAYS BUILDING			1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	160,748,340		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	5,496,249		30.00
31.00	03100	INTENSIVE CARE UNIT	1,070,247		31.00
43.00	04300	NURSERY	259,488		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	18,985,498		50.00
51.00	05100	RECOVERY ROOM	1,937,277		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	308,192		52.00
53.00	05300	ANESTHESIOLOGY	2,302,244		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,746,361		54.00
60.00	06000	LABORATORY	30,755,233		60.00
65.00	06500	RESPIRATORY THERAPY	9,981,267		65.00
66.00	06600	PHYSICAL THERAPY	2,099,654		66.00
67.00	06700	OCCUPATIONAL THERAPY	912,214		67.00
68.00	06800	SPEECH PATHOLOGY	516,408		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,064,429		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,254,788		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1,508,033		88.00
88.01	08801	RURAL HEALTH CLINIC II	4,327,003		88.01
88.02	08802	RURAL HEALTH CLINIC III	2,646,125		88.02
88.03	08803	RURAL HEALTH CLINIC IV	529,476		88.03
88.04	08804	RURAL HEALTH CLINIC V	812,280		88.04
88.05	08805	RURAL HEALTH CLINIC VI	2,974,761		88.05
91.00	09100	EMERGENCY	6,717,948		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	1,227,109		93.00
93.01	04951	SHAFER MEDICAL CENTER	3,881,008		93.01
93.02	04040	INTERNAL MEDICINE	1,435,048		93.02
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	160,748,340		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		192.00
192.01	19201	FCMC	0		192.01
192.02	19202	ARGOS MEDICAL CENTER	0		192.02
192.03	19203	AKRON MEDICAL CENTER	0		192.03
193.00	19300	NONPAID WORKERS	0		193.00
194.00	07950	ADVERTISING	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)	1,890,889		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.011763		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	88,605		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000551		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: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,910,706		5,910,706	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,386,228		1,386,228	0	0	31.00
43.00	04300	NURSERY	801,232		801,232	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,435,571		4,435,571	0	0	50.00
51.00	05100	RECOVERY ROOM	1,262,313		1,262,313	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	276,015		276,015	0	0	52.00
53.00	05300	ANESTHESIOLOGY	105,800		105,800	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,937,483		4,937,483	0	0	54.00
60.00	06000	LABORATORY	4,293,827		4,293,827	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,249,426	0	2,249,426	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,275,510	0	1,275,510	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	317,798	0	317,798	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	175,527	0	175,527	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	990,994		990,994	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,769,267		5,769,267	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,908,572		1,908,572	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,385,474		5,385,474	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,141,328		3,141,328	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	486,813		486,813	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,147,061		1,147,061	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	3,126,402		3,126,402	0	0	88.05
91.00	09100	EMERGENCY	3,740,940		3,740,940	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,442,717		1,442,717		0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	685,382		685,382	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	1,481,086		1,481,086	0	0	93.01
93.02	04040	INTERNAL MEDICINE	173,668		173,668	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	56,907,140	0	56,907,140	0	0	200.00
201.00		Less Observation Beds	1,442,717		1,442,717		0	201.00
202.00		Total (see instructions)	55,464,423	0	55,464,423	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,400,643		3,400,643			30.00
31.00	03100	INTENSIVE CARE UNIT	1,070,247		1,070,247			31.00
43.00	04300	NURSERY	259,488		259,488			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,057,547	14,927,951	18,985,498	0.233629	0.000000	50.00
51.00	05100	RECOVERY ROOM	354,027	1,583,250	1,937,277	0.651591	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	224,045	84,147	308,192	0.895594	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	283,085	2,019,159	2,302,244	0.045955	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,242,823	33,503,538	34,746,361	0.142101	0.000000	54.00
60.00	06000	LABORATORY	2,920,752	27,834,481	30,755,233	0.139613	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,443,281	6,537,986	9,981,267	0.225365	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	289,653	1,810,001	2,099,654	0.607486	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	95,694	816,520	912,214	0.348381	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	24,280	492,128	516,408	0.339900	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,253,532	810,897	2,064,429	0.480033	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,067,247	18,187,541	23,254,788	0.248089	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,508,033	1,508,033			88.00
88.01	08801	RURAL HEALTH CLINIC II	17	4,326,986	4,327,003			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,646,125	2,646,125			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	529,476	529,476			88.03
88.04	08804	RURAL HEALTH CLINIC V	0	812,280	812,280			88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	2,974,761	2,974,761			88.05
91.00	09100	EMERGENCY	234,392	6,483,556	6,717,948	0.556858	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	315,893	1,779,713	2,095,606	0.688449	0.000000	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	1,227,109	1,227,109	0.558534	0.000000	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	3,881,008	3,881,008	0.381624	0.000000	93.01
93.02	04040	INTERNAL MEDICINE	0	1,435,048	1,435,048	0.121019	0.000000	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	24,536,646	136,211,694	160,748,340			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	24,536,646	136,211,694	160,748,340			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
88.04	08804	RURAL HEALTH CLINIC V			88.04
88.05	08805	RURAL HEALTH CLINIC VI			88.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.000000		93.00
93.01	04951	SHAFER MEDICAL CENTER	0.000000		93.01
93.02	04040	INTERNAL MEDICINE	0.000000		93.02
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 11:35 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,910,706		5,910,706	0	5,910,706	30.00
31.00	03100	INTENSIVE CARE UNIT	1,386,228		1,386,228	0	1,386,228	31.00
43.00	04300	NURSERY	801,232		801,232	0	801,232	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,435,571		4,435,571	0	4,435,571	50.00
51.00	05100	RECOVERY ROOM	1,262,313		1,262,313	0	1,262,313	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	276,015		276,015	0	276,015	52.00
53.00	05300	ANESTHESIOLOGY	105,800		105,800	0	105,800	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,937,483		4,937,483	0	4,937,483	54.00
60.00	06000	LABORATORY	4,293,827		4,293,827	0	4,293,827	60.00
65.00	06500	RESPIRATORY THERAPY	2,249,426	0	2,249,426	0	2,249,426	65.00
66.00	06600	PHYSICAL THERAPY	1,275,510	0	1,275,510	0	1,275,510	66.00
67.00	06700	OCCUPATIONAL THERAPY	317,798	0	317,798	0	317,798	67.00
68.00	06800	SPEECH PATHOLOGY	175,527	0	175,527	0	175,527	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	990,994		990,994	0	990,994	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,769,267		5,769,267	0	5,769,267	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,908,572		1,908,572	0	1,908,572	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,385,474		5,385,474	0	5,385,474	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,141,328		3,141,328	0	3,141,328	88.02
88.03	08803	RURAL HEALTH CLINIC IV	486,813		486,813	0	486,813	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,147,061		1,147,061	0	1,147,061	88.04
88.05	08805	RURAL HEALTH CLINIC VI	3,126,402		3,126,402	0	3,126,402	88.05
91.00	09100	EMERGENCY	3,740,940		3,740,940	0	3,740,940	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,442,717		1,442,717		1,442,717	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	685,382		685,382	0	685,382	93.00
93.01	04951	SHAFER MEDICAL CENTER	1,481,086		1,481,086	0	1,481,086	93.01
93.02	04040	INTERNAL MEDICINE	173,668		173,668	0	173,668	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	56,907,140	0	56,907,140	0	56,907,140	200.00
201.00		Less Observation Beds	1,442,717		1,442,717		1,442,717	201.00
202.00		Total (see instructions)	55,464,423	0	55,464,423	0	55,464,423	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 11:35 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,400,643		3,400,643			30.00
31.00	03100	INTENSIVE CARE UNIT	1,070,247		1,070,247			31.00
43.00	04300	NURSERY	259,488		259,488			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,057,547	14,927,951	18,985,498	0.233629	0.000000	50.00
51.00	05100	RECOVERY ROOM	354,027	1,583,250	1,937,277	0.651591	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	224,045	84,147	308,192	0.895594	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	283,085	2,019,159	2,302,244	0.045955	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,242,823	33,503,538	34,746,361	0.142101	0.000000	54.00
60.00	06000	LABORATORY	2,920,752	27,834,481	30,755,233	0.139613	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,443,281	6,537,986	9,981,267	0.225365	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	289,653	1,810,001	2,099,654	0.607486	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	95,694	816,520	912,214	0.348381	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	24,280	492,128	516,408	0.339900	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,253,532	810,897	2,064,429	0.480033	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,067,247	18,187,541	23,254,788	0.248089	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,508,033	1,508,033	1.265604	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	17	4,326,986	4,327,003	1.244620	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,646,125	2,646,125	1.187143	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	529,476	529,476	0.919424	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	812,280	812,280	1.412150	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	2,974,761	2,974,761	1.050976	0.000000	88.05
91.00	09100	EMERGENCY	234,392	6,483,556	6,717,948	0.556858	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	315,893	1,779,713	2,095,606	0.688449	0.000000	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	1,227,109	1,227,109	0.558534	0.000000	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	3,881,008	3,881,008	0.381624	0.000000	93.01
93.02	04040	INTERNAL MEDICINE	0	1,435,048	1,435,048	0.121019	0.000000	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	24,536,646	136,211,694	160,748,340			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	24,536,646	136,211,694	160,748,340			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 11:35 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		88.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.000000		93.00
93.01	04951	SHAFER MEDICAL CENTER	0.000000		93.01
93.02	04040	INTERNAL MEDICINE	0.000000		93.02
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	230,959	18,985,498	0.012165	1,188,208	14,455	50.00
51.00	05100	RECOVERY ROOM	128,542	1,937,277	0.066352	85,501	5,673	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,904	308,192	0.067828	3,784	257	52.00
53.00	05300	ANESTHESIOLOGY	4,902	2,302,244	0.002129	82,271	175	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	333,793	34,746,361	0.009607	408,863	3,928	54.00
60.00	06000	LABORATORY	102,129	30,755,233	0.003321	888,147	2,950	60.00
65.00	06500	RESPIRATORY THERAPY	118,206	9,981,267	0.011843	1,145,707	13,569	65.00
66.00	06600	PHYSICAL THERAPY	84,343	2,099,654	0.040170	107,159	4,305	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,352	912,214	0.002578	32,116	83	67.00
68.00	06800	SPEECH PATHOLOGY	1,279	516,408	0.002477	12,122	30	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,696	2,064,429	0.002759	385,150	1,063	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,946	23,254,788	0.003137	1,312,241	4,117	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	69,692	1,508,033	0.046214	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	215,773	4,327,003	0.049867	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	16,122	2,646,125	0.006093	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,558	529,476	0.004831	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	52,666	812,280	0.064837	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	122,598	2,974,761	0.041213	0	0	88.05
91.00	09100	EMERGENCY	188,782	6,717,948	0.028101	3,144	88	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	129,729	2,095,606	0.061905	40,148	2,485	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	141,361	1,227,109	0.115198	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	70,730	3,881,008	0.018225	0	0	93.01
93.02	04040	INTERNAL MEDICINE	11,487	1,435,048	0.008005	0	0	93.02
200.00		Total (lines 50 through 199)	2,127,549	156,017,962		5,694,561	53,178	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	0	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0	0	0	0	0	93.02
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: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	18,985,498	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,937,277	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	308,192	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,302,244	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	34,746,361	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	30,755,233	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,981,267	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,099,654	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	912,214	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	516,408	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,064,429	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	23,254,788	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,508,033	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	4,327,003	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,646,125	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	529,476	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	812,280	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	2,974,761	0.000000	88.05
91.00	09100	EMERGENCY	0	0	0	6,717,948	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,095,606	0.000000	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	0	0	1,227,109	0.000000	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	3,881,008	0.000000	93.01
93.02	04040	INTERNAL MEDICINE	0	0	0	1,435,048	0.000000	93.02
200.00		Total (lines 50 through 199)	0	0	0	156,017,962		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,188,208	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	85,501	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	3,784	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	82,271	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	408,863	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	888,147	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,145,707	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	107,159	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	32,116	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	12,122	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	385,150	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,312,241	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	88.05
91.00	09100	EMERGENCY	0.000000	3,144	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	40,148	0	0	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.000000	0	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0.000000	0	0	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0.000000	0	0	0	0	93.02
200.00		Total (lines 50 through 199)		5,694,561	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.233629	0	2,057,020	0	0	50.00
51.00	05100	RECOVERY ROOM	0.651591	0	175,585	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.895594	0	1,160	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.045955	0	341,681	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142101	0	7,437,854	0	0	54.00
60.00	06000	LABORATORY	0.139613	0	5,885,082	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.225365	0	1,654,153	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.607486	0	487,877	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.348381	0	258,481	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.339900	0	10,529	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.480033	0	115,714	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.248089	0	5,649,946	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
88.04	08804	RURAL HEALTH CLINIC V						88.04
88.05	08805	RURAL HEALTH CLINIC VI						88.05
91.00	09100	EMERGENCY	0.556858	0	1,123,936	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.688449	0	342,186	1,800	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.558534	0	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0.381624	0	0	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0.121019	0	0	0	0	93.02
200.00		Subtotal (see instructions)		0	25,541,204	1,800	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	25,541,204	1,800	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	480,580	0		50.00
51.00	05100	RECOVERY ROOM	114,410	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,039	0		52.00
53.00	05300	ANESTHESIOLOGY	15,702	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,056,926	0		54.00
60.00	06000	LABORATORY	821,634	0		60.00
65.00	06500	RESPIRATORY THERAPY	372,788	0		65.00
66.00	06600	PHYSICAL THERAPY	296,378	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	90,050	0		67.00
68.00	06800	SPEECH PATHOLOGY	3,579	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	55,547	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,401,689	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08804	RURAL HEALTH CLINIC V				88.04
88.05	08805	RURAL HEALTH CLINIC VI				88.05
91.00	09100	EMERGENCY	625,873	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	235,578	1,239		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	0		93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0		93.01
93.02	04040	INTERNAL MEDICINE	0	0		93.02
200.00		Subtotal (see instructions)	5,571,773	1,239		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,571,773	1,239		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,237	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,112	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)	2,329	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	92	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	33	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)	815	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)	92	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	216.95	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	216.95	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,910,706	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)	7,159	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)	176,675	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,734,031	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)	5,734,031	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)	1,842.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,501,686	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)	1,501,686	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,386,228	379	3,657.59	120	438,911	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)	1,401,017	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,341,614	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)	169,516	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)	169,516	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)	783	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,842.55	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,442,717	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	531,489	5,910,706	0.089920	1,442,717	129,729	90.00
91.00	Nursing Program cost	0	5,910,706	0.000000	1,442,717	0	91.00
92.00	Allied health cost	0	5,910,706	0.000000	1,442,717	0	92.00
93.00	All other Medical Education	0	5,910,706	0.000000	1,442,717	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 11:35 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,237	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,112	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)	2,329	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	92	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	33	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)	46	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)	311	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	216.95	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	216.95	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,910,706	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)	7,159	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)	176,675	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,734,031	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)	5,734,031	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)	1,842.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	84,758	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)	84,758	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 11:35 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	801,232	311	2,576.31	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,386,228	379	3,657.59	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	55,582	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	140,340	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)	783	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,842.55	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,442,717	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 11:35 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	531,489	5,910,706	0.089920	1,442,717	129,729	90.00
91.00	Nursing Program cost	0	5,910,706	0.000000	1,442,717	0	91.00
92.00	Allied health cost	0	5,910,706	0.000000	1,442,717	0	92.00
93.00	All other Medical Education	0	5,910,706	0.000000	1,442,717	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,112,934		30.00
31.00	03100	INTENSIVE CARE UNIT		344,060		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.233629	1,188,208	277,600	50.00
51.00	05100	RECOVERY ROOM	0.651591	85,501	55,712	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.895594	3,784	3,389	52.00
53.00	05300	ANESTHESIOLOGY	0.045955	82,271	3,781	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142101	408,863	58,100	54.00
60.00	06000	LABORATORY	0.139613	888,147	123,997	60.00
65.00	06500	RESPIRATORY THERAPY	0.225365	1,145,707	258,202	65.00
66.00	06600	PHYSICAL THERAPY	0.607486	107,159	65,098	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.348381	32,116	11,189	67.00
68.00	06800	SPEECH PATHOLOGY	0.339900	12,122	4,120	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.480033	385,150	184,885	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.248089	1,312,241	325,553	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
91.00	09100	EMERGENCY	0.556858	3,144	1,751	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.688449	40,148	27,640	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.558534	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0.381624	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0.121019	0	0	93.02
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,694,561	1,401,017	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)		5,694,561		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1313 | Component CCN: 15-Z313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.233629	408	95	50.00
51.00	05100	RECOVERY ROOM	0.651591	2	1	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.895594	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.045955	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142101	7,459	1,060	54.00
60.00	06000	LABORATORY	0.139613	11,889	1,660	60.00
65.00	06500	RESPIRATORY THERAPY	0.225365	13,807	3,112	65.00
66.00	06600	PHYSICAL THERAPY	0.607486	32,036	19,461	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.348381	17,561	6,118	67.00
68.00	06800	SPEECH PATHOLOGY	0.339900	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.480033	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.248089	31,022	7,696	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
91.00	09100	EMERGENCY	0.556858	3	2	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.688449	83	57	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.558534	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0.381624	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0.121019	0	0	93.02
200.00		Total (sum of lines 50 through 94 and 96 through 98)		114,270	39,262	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)		114,270		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 11:35 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		51,199		30.00
31.00	03100	INTENSIVE CARE UNIT		11,382		31.00
43.00	04300	NURSERY		23,731		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.233629	52,043	12,159	50.00
51.00	05100	RECOVERY ROOM	0.651591	5,272	3,435	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.895594	7,493	6,711	52.00
53.00	05300	ANESTHESIOLOGY	0.045955	4,100	188	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142101	12,928	1,837	54.00
60.00	06000	LABORATORY	0.139613	39,712	5,544	60.00
65.00	06500	RESPIRATORY THERAPY	0.225365	26,016	5,863	65.00
66.00	06600	PHYSICAL THERAPY	0.607486	991	602	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.348381	280	98	67.00
68.00	06800	SPEECH PATHOLOGY	0.339900	71	24	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.480033	2,291	1,100	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.248089	50,493	12,527	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.265604	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.244620	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.187143	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.919424	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1.412150	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1.050976	0	0	88.05
91.00	09100	EMERGENCY	0.556858	9,866	5,494	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.688449	0	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.558534	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0.381624	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0.121019	0	0	93.02
200.00		Total (sum of lines 50 through 94 and 96 through 98)		211,556	55,582	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)		211,556		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1313	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 11:35 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,573,012	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,573,012	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	5,628,742	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)	71,366	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,942,762	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,614,614	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,614,614	30.00
31.00	Primary payer payments	265	31.00
32.00	Subtotal (line 30 minus line 31)	1,614,349	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)	342,138	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	222,390	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	282,053	36.00
37.00	Subtotal (see instructions)	1,836,739	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)	1,836,739	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	2,571,510	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)	-734,771	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: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,786,936		2,571,510	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/14/2021	254,300		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)		254,300		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)		3,041,236		2,571,510	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		59,728		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		734,771	6.02
7.00	Total Medicare program liability (see instructions)		3,100,964		1,836,739	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: 15-1313 | Component CCN: 15-Z313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		198,618		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)		198,618		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		10,949		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		209,567		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: 15-1313	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/26/2022 11:35 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1313 Component CCN: 15-Z313	Period: From 01/01/2021 To 12/31/2021	Worksheet E-2 Date/Time Prepared: 5/26/2022 11:35 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	171,211	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)	39,655	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	92	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)	210,866	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	210,866	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)	210,866	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,299	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	209,567	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)	209,567	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	198,618	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)	10,949	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: 15-1313	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prepared: 5/26/2022 11:35 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,341,614	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)	3,341,614	4.00
5.00	Primary payer payments	1,761	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,373,269	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)	3,373,269	19.00
20.00	Deductibles (exclude professional component)	290,636	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,082,633	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,082,633	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	28,201	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	18,331	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	22,493	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,100,964	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)	3,100,964	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	3,041,236	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)	59,728	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: 15-1313	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2022 11:35 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	140,340		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)	140,340	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)	140,340	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	86,312		8.00
9.00	Ancillary service charges	211,556	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)	297,868	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)	297,868	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	157,528	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)	140,340	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)	140,340	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)	140,340	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)	140,340	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	140,340	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)	140,340	0	40.00
41.00	Interim payments	126,868	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	13,472	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: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/26/2022 11:35 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	15,577,170	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	24,389,232	0	0	0	4.00
5.00	Other receivable	1,098,866	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-14,741,561	0	0	0	6.00
7.00	Inventory	1,154,671	0	0	0	7.00
8.00	Prepaid expenses	207,666	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)	27,686,044	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	596,216	0	0	0	12.00
13.00	Land improvements	513,782	0	0	0	13.00
14.00	Accumulated depreciation	-447,538	0	0	0	14.00
15.00	Buildings	27,528,763	0	0	0	15.00
16.00	Accumulated depreciation	-15,045,659	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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	11,394,525	0	0	0	23.00
24.00	Accumulated depreciation	-7,420,082	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)	17,120,007	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	8,664,210	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	567,299	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,231,509	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	54,037,560	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,144,594	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,967,316	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,206,969	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	600,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,918,879	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,442,141	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)	8,442,141	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,361,020	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	34,676,540				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)	34,676,540	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	54,037,560	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 | Date/Time Prepared: 5/26/2022 11:35 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		30,442,237		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,234,303				2.00
3.00	Total (sum of line 1 and line 2)		34,676,540		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		34,676,540		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)		34,676,540		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2022 11:35 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,220,944		4,220,944	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)	4,220,944		4,220,944	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,208,773		1,208,773	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,208,773		1,208,773	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,429,717		5,429,717	17.00
18.00	Ancillary services	19,261,076	122,032,760	141,293,836	18.00
19.00	Outpatient services	0	19,822	19,822	19.00
20.00	RURAL HEALTH CLINIC	0	1,508,033	1,508,033	20.00
20.01	RURAL HEALTH CLINIC II	17	4,326,986	4,327,003	20.01
20.02	RURAL HEALTH CLINIC III	0	2,646,125	2,646,125	20.02
20.03	RURAL HEALTH CLINIC IV	0	529,476	529,476	20.03
20.04	RURAL HEALTH CLINIC V	0	812,280	812,280	20.04
20.05	RURAL HEALTH CLINIC VI	0	2,974,761	2,974,761	20.05
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER OUTPATIENT	0	1,227,109	1,227,109	27.00
27.01	PROFESSIONAL FEES	0	4,071,754	4,071,754	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	24,690,810	140,149,106	164,839,916	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		66,183,288		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)		66,183,288		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-3 | Date/Time Prepared: 5/26/2022 11:35 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	164,839,916	1.00
2.00	Less contractual allowances and discounts on patients' accounts	103,916,862	2.00
3.00	Net patient revenues (line 1 minus line 2)	60,923,054	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	66,183,288	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,260,234	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	17,959	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	129,137	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	5	21.00
22.00	Rental of hospital space	3,888	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	531,295	24.00
24.01	LTC REVENUE	3,840,357	24.01
24.02	GAIN/LOSS DISP ASSET-MISC	0	24.02
24.03	340B	913,724	24.03
24.04	DONATIONS FROM FOUNDATION	60,327	24.04
24.50	COVID-19 PHE Funding	3,997,845	24.50
25.00	Total other income (sum of lines 6-24)	9,494,537	25.00
26.00	Total (line 5 plus line 25)	4,234,303	26.00
27.00	OTHER EXPENSES	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)	4,234,303	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1313 | Component CCN: 15-8551 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/26/2022 11:35 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	451,424	0	451,424	0	451,424	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	168,441	0	168,441	0	168,441	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	41,266	0	41,266	0	41,266	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	113,614	0	113,614	0	113,614	9.00
10.00	Subtotal (sum of lines 1 through 9)	774,745	0	774,745	0	774,745	10.00
11.00	Physician Services Under Agreement	0	503,704	503,704	0	503,704	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	503,704	503,704	0	503,704	14.00
15.00	Medical Supplies	0	14,237	14,237	0	14,237	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14,237	14,237	0	14,237	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	774,745	517,941	1,292,686	0	1,292,686	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	4,927	4,927	-190	4,737	29.00
30.00	Administrative Costs	27,560	172,042	199,602	26,796	226,398	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	27,560	176,969	204,529	26,606	231,135	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	802,305	694,910	1,497,215	26,606	1,523,821	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8551 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/26/2022 11:35 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-252,369	199,055		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-137	168,304		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	41,266		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	113,614		9.00
10.00	Subtotal (sum of lines 1 through 9)	-252,506	522,239		10.00
11.00	Physician Services Under Agreement	0	503,704		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	503,704		14.00
15.00	Medical Supplies	0	14,237		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14,237		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-252,506	1,040,180		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	4,737		29.00
30.00	Administrative Costs	0	226,398		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	231,135		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-252,506	1,271,315		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8552 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/26/2022 11:35 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	2,042,825	84,224	2,127,049	28,048	2,155,097	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	148,842	0	148,842	0	148,842	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	240,865	0	240,865	0	240,865	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,432,532	84,224	2,516,756	28,048	2,544,804	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	456,319	456,319	0	456,319	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	456,319	456,319	0	456,319	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,432,532	540,543	2,973,075	28,048	3,001,123	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	525,959	525,959	-525,959	0	29.00
30.00	Administrative Costs	535,394	507,753	1,043,147	-173,872	869,275	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	535,394	1,033,712	1,569,106	-699,831	869,275	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,967,926	1,574,255	4,542,181	-671,783	3,870,398	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8552 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/26/2022 11:35 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-179,048	1,976,049		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-217	148,625		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	240,865		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-179,265	2,365,539		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	456,319		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	456,319		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-179,265	2,821,858		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	0		29.00
30.00	Administrative Costs	0	869,275		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	869,275		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-179,265	3,691,133		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8550 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/26/2022 11:35 am

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	994,242	6,906	1,001,148	0	1,001,148	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	148,610	0	148,610	0	148,610	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	98,075	0	98,075	0	98,075	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,240,927	6,906	1,247,833	0	1,247,833	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	144,757	144,757	0	144,757	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	144,757	144,757	0	144,757	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,240,927	151,663	1,392,590	0	1,392,590	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	182,390	182,390	-35,299	147,091	29.00
30.00	Administrative Costs	228,516	640,426	868,942	52,889	921,831	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	228,516	822,816	1,051,332	17,590	1,068,922	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,469,443	974,479	2,443,922	17,590	2,461,512	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1313 | Component CCN: 15-8550 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/26/2022 11:35 am

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-18,362	982,786		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-69	148,541		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	98,075		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-18,431	1,229,402		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	144,757		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	144,757		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-18,431	1,374,159		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	147,091		29.00
30.00	Administrative Costs	0	921,831		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	1,068,922		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-18,431	2,443,081		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8549 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/26/2022 11:35 am

RHC IV | 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	180,066	3,968	184,034	0	184,034	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	12,269	0	12,269	0	12,269	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	29,854	0	29,854	0	29,854	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	222,189	3,968	226,157	0	226,157	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	30,182	30,182	0	30,182	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	30,182	30,182	0	30,182	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	222,189	34,150	256,339	0	256,339	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	11,703	11,703	35,299	47,002	29.00
30.00	Administrative Costs	19,678	38,654	58,332	12,964	71,296	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	19,678	50,357	70,035	48,263	118,298	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	241,867	84,507	326,374	48,263	374,637	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1313 | Component CCN: 15-8549 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/26/2022 11:35 am

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	184,034		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	12,269		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	29,854		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	226,157		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	30,182		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	30,182		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	256,339		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	47,002		29.00
30.00	Administrative Costs	0	71,296		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	118,298		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	374,637		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8547 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/26/2022 11:35 am

RHC V | 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	363,075	10,276	373,351	0	373,351	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	102,383	0	102,383	0	102,383	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,368	0	1,368	0	1,368	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	466,826	10,276	477,102	0	477,102	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	1,809	1,809	0	1,809	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,809	1,809	0	1,809	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	466,826	12,085	478,911	0	478,911	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	30,829	30,829	0	30,829	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	30,829	30,829	0	30,829	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	14,792	14,792	0	14,792	29.00
30.00	Administrative Costs	91,092	158,590	249,682	3,494	253,176	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	91,092	173,382	264,474	3,494	267,968	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	557,918	216,296	774,214	3,494	777,708	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1313 | Component CCN: 15-8547 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/26/2022 11:35 am

RHC V | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-1,046	372,305		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-4,199	98,184		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	1,368		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-5,245	471,857		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	1,809		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,809		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-5,245	473,666		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	30,829		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	30,829		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	14,792		29.00
30.00	Administrative Costs	0	253,176		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	267,968		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-5,245	772,463		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8548 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/26/2022 11:35 am

RHC VI | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,173,744	13,121	1,186,865	0	1,186,865	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	178,143	0	178,143	0	178,143	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	42,510	0	42,510	0	42,510	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,394,397	13,121	1,407,518	0	1,407,518	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	121,172	121,172	0	121,172	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	121,172	121,172	0	121,172	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,394,397	134,293	1,528,690	0	1,528,690	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	36,272	36,272	0	36,272	29.00
30.00	Administrative Costs	187,553	387,087	574,640	29,207	603,847	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	187,553	423,359	610,912	29,207	640,119	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,581,950	557,652	2,139,602	29,207	2,168,809	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8548 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/26/2022 11:35 am

RHC VI | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-19,710	1,167,155		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-1,887	176,256		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	42,510		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-21,597	1,385,921		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	121,172		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	121,172		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-21,597	1,507,093		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	36,272		29.00
30.00	Administrative Costs	0	603,847		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	640,119		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-21,597	2,147,212		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1313 Component CCN: 15-8551

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

Worksheet M-2

Date/Time Prepared: 5/26/2022 11:35 am

RHC I

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.34	901	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.60	2,136	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.94	3,037		1	3,037	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.94	3,037			3,037	8.00
9.00	Physician Services Under Agreements		3,412			3,412	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)					1,040,180	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)					1,040,180	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)					231,135	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					637,257	15.00
16.00	Total overhead (sum of lines 14 and 15)					868,392	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					868,392	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					868,392	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,908,572	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1313 | Component CCN: 15-8552 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-2 | Date/Time Prepared: 5/26/2022 11:35 am

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	4.05	13,723	1	4		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.67	2,076	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.72	15,799		5	15,799	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.72	15,799			15,799	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)					2,821,858	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)					2,821,858	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)					869,275	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,694,341	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,563,616	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,563,616	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,563,616	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					5,385,474	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1313 | Component CCN: 15-8550 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-2 | Date/Time Prepared: 5/26/2022 11:35 am

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.24	11,841	1	2		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.40	888	1	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.64	12,729		2	12,729	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.64	12,729			12,729	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)					1,374,159	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)					1,374,159	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,068,922	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					698,247	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,767,169	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,767,169	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,767,169	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,141,328	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1313 | Component CCN: 15-8549 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-2 | Date/Time Prepared: 5/26/2022 11:35 am

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.44	2,337	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.40	783	1	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.84	3,120		0	3,120	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.84	3,120			3,120	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)					256,339	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)					256,339	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)					118,298	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					112,176	15.00
16.00	Total overhead (sum of lines 14 and 15)					230,474	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					230,474	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					230,474	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					486,813	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1313 | Component CCN: 15-8547 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-2 | Date/Time Prepared: 5/26/2022 11:35 am

RHC V | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.91	2,625	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.83	1,773	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.74	4,398		2	4,398	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.74	4,398			4,398	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)					473,666	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					30,829	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					504,495	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.938891	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					267,968	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					374,598	15.00
16.00	Total overhead (sum of lines 14 and 15)					642,566	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					642,566	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					603,299	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,076,965	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1313 | Component CCN: 15-8548 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-2 | Date/Time Prepared: 5/26/2022 11:35 am

RHC VI | 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	2.04	11,186	1	2		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.74	4,573	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.78	15,759		3	15,759	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.78	15,759			15,759	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)					1,507,093	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)					1,507,093	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)					640,119	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					979,190	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,619,309	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,619,309	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,619,309	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,126,402	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1313 Component CCN: 15-8551	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/26/2022 11:35 am
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,908,572	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		16,470	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,892,102	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,037	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		3,412	5.00
6.00	Total adjusted visits (line 4 plus line 5)		6,449	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		293.39	7.00

		Calculation of Limit (1)		
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	264.14	8.00
9.00	Rate for Program covered visits (see instructions)	293.39	264.14	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	349	1,250	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	102,393	330,175	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	432,568	16.00
16.01	Total program charges (see instructions)(from contractor's records)		250,401	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,933	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		5,067	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.)		315,483	16.04
16.05	Total program cost (see instructions)	0	320,550	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		33,147	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		42,864	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		320,550	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		7,199	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		327,749	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)		327,749	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		251,811	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)		75,938	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1313 Component CCN: 15-8552	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/26/2022 11:35 am
	Title XVIII	RHC II	Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	5,385,474	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	176,208	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	5,209,266	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	15,799	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)	15,799	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	329.72	7.00

		Calculation of Limit (1)		
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	394.94	8.00
9.00	Rate for Program covered visits (see instructions)	329.72	329.72	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	160	425	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	52,755	140,131	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	192,886	16.00
16.01	Total program charges (see instructions)(from contractor's records)		93,110	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,401	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		7,046	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.)		138,446	16.04
16.05	Total program cost (see instructions)	0	145,492	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		12,782	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		15,386	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		145,492	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,494	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		146,986	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)		146,986	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		107,496	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)		39,490	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1313 Component CCN: 15-8550	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/26/2022 11:35 am
	Title XVIII	RHC III	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		3,141,328	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		109,701	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3,031,627	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		12,729	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)		12,729	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		238.17	7.00

		Calculation of Limit (1)		
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	237.38	8.00
9.00	Rate for Program covered visits (see instructions)	238.17	237.38	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	477	1,329	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	113,607	315,478	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	429,085	16.00
16.01	Total program charges (see instructions)(from contractor's records)		272,973	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,124	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,910	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.)		306,564	16.04
16.05	Total program cost (see instructions)	0	311,474	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		40,970	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		45,776	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		311,474	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		33,106	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		344,580	22.00
23.00	Allowable bad debts (see instructions)		22	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		14	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)		344,594	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		209,633	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)		134,961	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1313 Component CCN: 15-8549	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/26/2022 11:35 am
	Title XVIII	RHC IV	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)		486,813	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		17,584	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		469,229	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,120	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)		3,120	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		150.39	7.00

		Calculation of Limit (1)		
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	237.51	8.00
9.00	Rate for Program covered visits (see instructions)	150.39	150.39	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	168	502	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	25,266	75,496	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	100,762	16.00
16.01	Total program charges (see instructions)(from contractor's records)		100,073	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	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.)		67,188	16.04
16.05	Total program cost (see instructions)	0	67,188	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		16,777	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		16,659	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		67,188	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		7,387	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		74,575	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)		74,575	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		47,572	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)		27,003	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1313 Component CCN: 15-8547	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/26/2022 11:35 am
	Title XVIII	RHC V	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,076,965	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			26,132	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,050,833	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,398	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			4,398	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			238.93	7.00
		Calculation of Limit (1)			
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	287.67		8.00
9.00	Rate for Program covered visits (see instructions)	238.93	238.93		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	150	546		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	35,840	130,456		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	166,296		16.00
16.01	Total program charges (see instructions)(from contractor's records)		110,972		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,437		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		8,148		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.)		112,137		16.04
16.05	Total program cost (see instructions)	0	120,285		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		17,977		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		17,512		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		120,285		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		8,700		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		128,985		22.00
23.00	Allowable bad debts (see instructions)		66		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		43		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)		129,028		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		70,027		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)		59,001		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1313 Component CCN: 15-8548	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/26/2022 11:35 am
	Title XVIII	RHC VI	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)		3,126,402	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		84,115	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3,042,287	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		15,759	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)		15,759	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		193.05	7.00

		Calculation of Limit (1)		
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	207.80	8.00
9.00	Rate for Program covered visits (see instructions)	193.05	193.05	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	531	1,605	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	102,510	309,845	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	412,355	16.00
16.01	Total program charges (see instructions)(from contractor's records)		323,672	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		17,539	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		22,345	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.)		275,568	16.04
16.05	Total program cost (see instructions)	0	297,913	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		45,550	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		52,117	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		297,913	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		24,627	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		322,540	22.00
23.00	Allowable bad debts (see instructions)		144	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		94	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)		322,634	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		205,989	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)		116,645	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: 15-1313 | Component CCN: 15-8551 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	522,239	522,239	522,239	522,239	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000271	0.002052	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	142	1,072	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2,246	5,516	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,388	6,588	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,040,180	1,040,180	1,040,180	1,040,180	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	868,392	868,392	868,392	868,392	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.002296	0.006334	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,994	5,500	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	4,382	12,088	0	0	10.00
11.00	Total number of injections/infusions (from your records)	21	159	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	208.67	76.03	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	13	59	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2,713	4,486	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)		16,470			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		7,199			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-8552 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,365,539	2,365,539	2,365,539	2,365,539	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001853	0.003024	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	4,383	7,153	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	52,833	27,960	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	57,216	35,113	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,821,858	2,821,858	2,821,858	2,821,858	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,563,616	2,563,616	2,563,616	2,563,616	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.020276	0.012443	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	51,980	31,899	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	109,196	67,012	0	0	10.00
11.00	Total number of injections/infusions (from your records)	494	806	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	221.04	83.14	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	3	10	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)	663	831	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)		176,208			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		1,494			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-8550 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | RHC III | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,229,402	1,229,402	1,229,402	1,229,402	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001224	0.003128	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,505	3,846	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	23,315	19,322	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	24,820	23,168	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,374,159	1,374,159	1,374,159	1,374,159	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,767,169	1,767,169	1,767,169	1,767,169	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.018062	0.016860	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	31,919	29,794	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	56,739	52,962	0	0	10.00
11.00	Total number of injections/infusions (from your records)	218	557	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	260.27	95.08	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	64	173	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)	16,657	16,449	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)		109,701			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)		33,106			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-8549 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | RHC IV | 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)	226,157	226,157	226,157	226,157	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000859	0.013738	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	194	3,107	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	963	4,995	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,157	8,102	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	256,339	256,339	256,339	256,339	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	230,474	230,474	230,474	230,474	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.004514	0.031607	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,040	7,285	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	2,197	15,387	0	0	10.00
11.00	Total number of injections/infusions (from your records)	9	144	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	244.11	106.85	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	4	60	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)	976	6,411	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)		17,584			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		7,387			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-8547 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | RHC V | 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)	471,857	471,857	471,857	471,857	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000348	0.003057	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	164	1,442	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2,567	7,320	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,731	8,762	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	473,666	473,666	473,666	473,666	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	603,299	603,299	603,299	603,299	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.005766	0.018498	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,479	11,160	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6,210	19,922	0	0	10.00
11.00	Total number of injections/infusions (from your records)	24	211	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	258.75	94.42	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	11	62	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2,846	5,854	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)		26,132			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		8,700			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-8548 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/26/2022 11:35 am

Title XVIII | RHC VI | 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)	1,385,921	1,385,921	1,385,921	1,385,921	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000717	0.003206	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	994	4,443	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	14,331	20,779	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	15,325	25,222	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,507,093	1,507,093	1,507,093	1,507,093	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,619,309	1,619,309	1,619,309	1,619,309	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.010169	0.016736	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	16,467	27,101	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	31,792	52,323	0	0	10.00
11.00	Total number of injections/infusions (from your records)	134	599	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	237.25	87.35	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	39	176	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)	9,253	15,374	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)		84,115			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)		24,627			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1313 Component CCN: 15-8551	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/26/2022 11:35 am

RHC I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		251,811	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)		251,811	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		75,938	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		327,749	7.00

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

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

Provider CCN: 15-1313 | Component CCN: 15-8552 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-5 | Date/Time Prepared: 5/26/2022 11:35 am

RHC II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		107,496	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)		107,496	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		39,490	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		146,986	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1313 Component CCN: 15-8550	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/26/2022 11:35 am
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		209,633	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)		209,633	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		134,961	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		344,594	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1313 Component CCN: 15-8549	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/26/2022 11:35 am
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		47,572	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)		47,572	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		27,003	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		74,575	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1313 Component CCN: 15-8547	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/26/2022 11:35 am
		RHC V	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		70,027	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)		70,027	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		59,001	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		129,028	7.00

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

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

Provider CCN: 15-1313 | Component CCN: 15-8548 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-5 | Date/Time Prepared: 5/26/2022 11:35 am

RHC VI | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		205,989	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)		205,989	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		116,645	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		322,634	7.00

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