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: 15-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 2/24/2022 4:28 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/24/2022 Time: 4:28 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CAMERON MEMORIAL COMMUNITY HOSPITAL (15-1315) for the cost reporting period beginning 10/01/2020 and ending 09/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Angie Logan		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	Angie Logan			2
3	Signatory Title	CEO			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	-487,386	-206,013	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	-249,015	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		25,589		0	10.00
10.01	RURAL HEALTH CLINIC II	0		24,575		0	10.01
10.02	RURAL HEALTH CLINIC III	0		4,656		0	10.02
200.00	Total	0	-736,401	-151,193	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2022 4:28 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 416 E MAUMEE STREET	PO Box:			1.00
2.00	City: ANGOLA	State: IN	Zip Code: 47803-	County: STEUBEN	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	CAMERON MEMORIAL COMMUNITY HOSPITAL	151315	99915	1	02/01/2003	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	CAMERON MEMORIAL COMMUNITY	15Z315	99915		02/01/2003	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	CAMERON FAMILY MEDICINE	158530	99915		12/31/2016	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	CAMERON URGENT CARE	158545	99915		11/26/2019	N	O	O	15.01
15.02	Hospital-Based Health Clinic - RHC III	CAMERON OB/GYN	158546	99915		11/25/2019	N	O	O	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2020	09/30/2021	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-2 Part I | Date/Time Prepared: 2/24/2022 4:28 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2022 4:28 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2022 4:28 pm

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

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		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

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				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:	29,252	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

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

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

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

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

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	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)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

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		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: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-2 Part II | Date/Time Prepared: 2/24/2022 4:28 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/21/2021	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	11/30/2021	Y	11/30/2021	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-2 Part II | Date/Time Prepared: 2/24/2022 4:28 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	Y	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	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y	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.	Y	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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.	JODI	SANDERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7956	JSANDERS@BLUEANDCO.COM	43.00

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		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		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: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-3 Part I Date/Time Prepared: 2/24/2022 4:28 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	23	8,395	78,744.00	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)		23	8,395	78,744.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	2	730	3,024.00	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	81,768.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		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

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	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)	840	23	3,281			1.00
2.00	HMO and other (see instructions)	1,106	253				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	613	0	613			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	812			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,453	23	4,706			7.00
8.00	INTENSIVE CARE UNIT	52	0	126			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		7	426			13.00
14.00	Total (see instructions)	1,505	30	5,258	0.00	421.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,322	2,362	9,054	0.00	13.29	26.00
26.01	RURAL HEALTH CLINIC II	999	3,487	14,624	0.00	18.29	26.01
26.02	RURAL HEALTH CLINIC III	88	1,443	3,842	0.00	8.52	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	461.10	27.00
28.00	Observation Bed Days		25	1,401			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-3 Part I | Date/Time Prepared: 2/24/2022 4:28 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	229	11	990	1.00
2.00	HMO and other (see instructions)			264	129		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	229	11	990	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-8 | Date/Time Prepared: 2/24/2022 4:28 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1500 W MAUMEE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANGOLOA		IN	46703	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?	N	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		STEUBEN				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: 15-1315
Component CCN: 15-8530

Period:
From 10/01/2020
To 09/30/2021

Worksheet S-8
Date/Time Prepared:
2/24/2022 4:28 pm

RHC I | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-8 | Date/Time Prepared: 2/24/2022 4:28 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1381 N. WAYNE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANGOLA		IN	46703	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	09:00	17:30	08:00	19:30	08:00	11.00

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

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

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19:30	08:00	19:30	08:00	19:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1315
Component CCN: 15-8545

Period:
From 10/01/2020
To 09/30/2021

Worksheet S-8
Date/Time Prepared:
2/24/2022 4:28 pm

RHC II | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	19:30	09:00	17:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-8 | Date/Time Prepared: 2/24/2022 4:28 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			306 E. MAUMEE STREET, SUITE 101		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANGOLA		IN	46703	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	16:30	08:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County						2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-8 | Date/Time Prepared: 2/24/2022 4:28 pm

RHC III | Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-10 | Date/Time Prepared: 2/24/2022 4:28 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.341275	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,500,629	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	22,888,788	6.00
7.00	Medicaid cost (line 1 times line 6)	7,811,371	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	4,310,742	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,310,742	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)	208,102	0	208,102	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	71,020	0	71,020	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)	71,020	0	71,020	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)	4,737,561	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	392,276	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	603,501	27.01
28.00	Non-Medicare bad debt expense (see instructions)	4,134,060	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,622,076	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,693,096	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,003,838	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A | Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		5,009,776	5,009,776	209,345	5,219,121	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,051,543	2,051,543	1,368,877	3,420,420	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	79,733	10,089,629	10,169,362	0	10,169,362	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,651,166	8,204,914	13,856,080	-167,967	13,688,113	5.00
7.00	00700	OPERATION OF PLANT	1,060,694	3,645,123	4,705,817	-19,326	4,686,491	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	48,546	48,546	0	48,546	8.00
9.00	00900	HOUSEKEEPING	880,221	640,158	1,520,379	0	1,520,379	9.00
10.00	01000	DIETARY	574,329	394,107	968,436	-629,871	338,565	10.00
11.00	01100	CAFETERIA	0	0	0	568,472	568,472	11.00
13.00	01300	NURSING ADMINISTRATION	598,958	48,411	647,369	0	647,369	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	223,889	213,445	437,334	0	437,334	14.00
15.00	01500	PHARMACY	859,749	4,442,340	5,302,089	-3,800,842	1,501,247	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	589,511	94,344	683,855	0	683,855	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,589,388	1,121,853	3,711,241	496,884	4,208,125	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	75,058	75,058	31.00
43.00	04300	NURSERY	0	0	0	12,053	12,053	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,613,337	1,478,777	3,092,114	-725,308	2,366,806	50.00
51.00	05100	RECOVERY ROOM	0	0	0	725,308	725,308	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,183,826	153,566	1,337,392	-585,171	752,221	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,968,458	990,694	2,959,152	0	2,959,152	54.00
60.00	06000	LABORATORY	1,052,270	2,287,724	3,339,994	0	3,339,994	60.00
65.00	06500	RESPIRATORY THERAPY	1,055,634	179,707	1,235,341	-227,898	1,007,443	65.00
65.01	06501	SLEEP LAB	0	0	0	75,814	75,814	65.01
66.00	06600	PHYSICAL THERAPY	1,043,565	21,441	1,065,006	0	1,065,006	66.00
69.00	06900	ELECTROCARDIOLOGY	0	6,861	6,861	152,084	158,945	69.00
69.01	06901	CARDIAC REHABILITATION	54,957	6,393	61,350	0	61,350	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,781,578	2,781,578	-1,829,666	951,912	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,829,666	1,829,666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	921,972	921,972	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	1,448,379	1,448,379	0	1,448,379	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,113,407	44,482	1,157,889	0	1,157,889	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,570,351	158,637	1,728,988	0	1,728,988	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,087,351	119,197	1,206,548	0	1,206,548	88.02
90.00	09000	CLINIC	132,200	19,525	151,725	0	151,725	90.00
90.01	09001	CLINIC- ORTHO	366,464	874,174	1,240,638	0	1,240,638	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	1,182,886	25,788	1,208,674	56,644	1,265,318	90.02
90.03	09003	INTRAVENOUS THERAPY	82,840	16,087	98,927	2,822,226	2,921,153	90.03
90.04	09004	PSYCHIATRY	668,436	13,259	681,695	0	681,695	90.04
90.05	09005	CARDIOLOGY	691,694	32,387	724,081	0	724,081	90.05
91.00	09100	EMERGENCY	1,965,996	288,549	2,254,545	1,176	2,255,721	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,485,960	1,485,960	-1,485,960	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,941,310	48,437,354	78,378,664	-156,430	78,222,234	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	3,049	3,049	0	3,049	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	229,717	834,642	1,064,359	50,759	1,115,118	194.05
194.06	07956	GUEST MEALS	0	0	0	61,399	61,399	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	127,857	2,005	129,862	0	129,862	194.12
194.13	07963	OCCUPATIONAL HEALTH	233,073	114,816	347,889	0	347,889	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	147,968	217,406	365,374	3,484	368,858	194.15

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A | Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	613,213	101,901	715,114	30,826	745,940	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	588,761	26,057	614,818	9,962	624,780	194.17
200.00		TOTAL (SUM OF LINES 118 through 199)	31,881,899	49,737,230	81,619,129	0	81,619,129	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A | Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-575,439	4,643,682		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-142,014	3,278,406		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-233,063	9,936,299		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,689,015	10,999,098		5.00
7.00	00700	OPERATION OF PLANT	0	4,686,491		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	48,546		8.00
9.00	00900	HOUSEKEEPING	0	1,520,379		9.00
10.00	01000	DIETARY	-6,688	331,877		10.00
11.00	01100	CAFETERIA	-176,340	392,132		11.00
13.00	01300	NURSING ADMINISTRATION	0	647,369		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-3,300	434,034		14.00
15.00	01500	PHARMACY	-9,060	1,492,187		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-723	683,132		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-758,554	3,449,571		30.00
31.00	03100	INTENSIVE CARE UNIT	0	75,058		31.00
43.00	04300	NURSERY	0	12,053		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-693,012	1,673,794		50.00
51.00	05100	RECOVERY ROOM	0	725,308		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	752,221		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,959,152		54.00
60.00	06000	LABORATORY	-2,521	3,337,473		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,007,443		65.00
65.01	06501	SLEEP LAB	0	75,814		65.01
66.00	06600	PHYSICAL THERAPY	0	1,065,006		66.00
69.00	06900	ELECTROCARDIOLOGY	0	158,945		69.00
69.01	06901	CARDIAC REHABILITATION	0	61,350		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	951,912		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,829,666		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	921,972		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0		76.00
76.01	03480	ONCOLOGY	-32,168	1,416,211		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,157,889		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,728,988		88.01
88.02	08802	RURAL HEALTH CLINIC III	-429,611	776,937		88.02
90.00	09000	CLINIC	0	151,725		90.00
90.01	09001	CLINIC- ORTHO	-999,379	241,259		90.01
90.02	09002	CLINIC - PEDS, ENT, FP	-1,169,614	95,704		90.02
90.03	09003	INTRAVENOUS THERAPY	0	2,921,153		90.03
90.04	09004	PSYCHIATRY	-647,063	34,632		90.04
90.05	09005	CARDIOLOGY	-578,646	145,435		90.05
91.00	09100	EMERGENCY	0	2,255,721		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0		114.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,146,210	69,076,024		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
194.00	07950	DAYCARE-INFANT/TODDLER	0	0		194.00
194.01	07951	MOB	0	0		194.01
194.02	07952	COMMUNITY HEALTH	0	3,049		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0		194.03
194.04	07954	EDUCATION	0	0		194.04
194.05	07955	MARKETING	0	1,115,118		194.05
194.06	07956	GUEST MEALS	0	61,399		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0		194.07
194.08	07958	CANCER CENTER	0	0		194.08
194.09	07959	URGENT CARE	0	0		194.09
194.10	07960	RHC	0	0		194.10
194.11	07961	OBGYN	0	0		194.11
194.12	07962	TRINE STUDENT HEALTH	0	129,862		194.12
194.13	07963	OCCUPATIONAL HEALTH	0	347,889		194.13
194.14	07964	IMMUNIZATION CLINIC	0	0		194.14
194.15	07965	FOUNDATION	0	368,858		194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	745,940		194.16

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A | Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	624,780		194.17
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,146,210	72,472,919		200.00

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-6 | Date/Time Prepared: 2/24/2022 4:28 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - LABOR AND DELIVERY					
1.00	ADULTS & PEDIATRICS	30.00	504,937	67,005		1.00
2.00	NURSERY	43.00	10,641	1,412		2.00
3.00	EMERGENCY	91.00	1,038	138		3.00
	0		516,616	68,555		
	B - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	73,097		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	14,306		2.00
	0		0	87,403		
	C - CAFETERIA					
1.00	CAFETERIA	11.00	337,131	231,341		1.00
2.00	GUEST MEALS	194.06	36,413	24,986		2.00
	0		373,544	256,327		
	D - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,482,858		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,102		2.00
	0		0	1,485,960		
	E - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,357,591		1.00
	0		0	1,357,591		
	F - ICU					
1.00	INTENSIVE CARE UNIT	31.00	67,583	7,475		1.00
	0		67,583	7,475		
	G - PROPERTY TAX					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	26,321		1.00
	0		0	26,321		
	H - SLEEP LAB - SALARIED STAFF					
1.00	SLEEP LAB	65.01	40,745	35,069		1.00
2.00	ELECTROCARDIOLOGY	69.00	18,179	65,687		2.00
	0		58,924	100,756		
	I - PUBLIC RELATIONS					
1.00	MARKETING	194.05	0	50,759		1.00
	0		0	50,759		
	J - RECOVERY ROOM					
1.00	RECOVERY ROOM	51.00	725,308			1.00
	0		725,308	0		
	K - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		1,829,666		1.00
	0		0	1,829,666		
	L - FOUNDATION RECLASS					
1.00	FOUNDATION	194.15	3,484	0		1.00
	0		3,484	0		
	M - IMMUNIZATION CLINIC RECLASS					
1.00	CLINIC - PEDS, ENT, FP	90.02	0	56,644		1.00
	0		0	56,644		
	N - DRUGS RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,744,198		1.00
	TOTALS		0	3,744,198		
	O - IV THERAPY					
1.00	INTRAVENOUS THERAPY	90.03	0	2,822,226		1.00
	TOTALS		0	2,822,226		
	P - EKG HST RECLASS					
1.00	ELECTROCARDIOLOGY	69.00	68,218	0		1.00
	TOTALS		68,218	0		
	Q - OFFSITE RECLASS					
1.00	CAMERON FAMILY MEDICINE - NORTH	194.16	0	30,826		1.00
2.00	CAMERON FAMILY MEDICINE - FREMONT	194.17	0	9,962		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	40,788		
500.00	Grand Total: Increases		1,813,677	11,934,669		500.00

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-6 | Date/Time Prepared: 2/24/2022 4:28 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LABOR AND DELIVERY						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	516,616	68,555	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		516,616	68,555			
	B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	87,403	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	87,403			
	C - CAFETERIA						
1.00	DIETARY	10.00	373,544	256,327	0		1.00
2.00		0.00	0	0	0		2.00
	0		373,544	256,327			
	D - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,485,960	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	1,485,960			
	E - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,357,591	9		1.00
	0		0	1,357,591			
	F - ICU						
1.00	ADULTS & PEDIATRICS	30.00	67,583	7,475	0		1.00
	0		67,583	7,475			
	G - PROPERTY TAX						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	26,321	13		1.00
	0		0	26,321			
	H - SLEEP LAB - SALARIED STAFF						
1.00	RESPIRATORY THERAPY	65.00	58,924	100,756	0		1.00
2.00		0.00	0	0	0		2.00
	0		58,924	100,756			
	I - PUBLIC RELATIONS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	50,759	0		1.00
	0		0	50,759			
	J - RECOVERY ROOM						
1.00	OPERATING ROOM	50.00	725,308		0		1.00
	0		725,308	0			
	K - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		1,829,666	0		1.00
	0		0	1,829,666			
	L - FOUNDATION RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	3,484	0	0		1.00
	0		3,484	0			
	M - IMMUNIZATION CLINIC RECLASS						
1.00	PHARMACY	15.00	0	56,644	0		1.00
	0		0	56,644			
	N - DRUGS RECLASS						
1.00	PHARMACY	15.00	0	3,744,198	0		1.00
	TOTALS		0	3,744,198			
	O - IV THERAPY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,822,226	0		1.00
	TOTALS		0	2,822,226			
	P - EKG HST RECLASS						
1.00	RESPIRATORY THERAPY	65.00	68,218	0	0		1.00
	TOTALS		68,218	0			
	Q - OFFSITE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	15,340	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,122	9		2.00
3.00	OPERATION OF PLANT	7.00	0	19,326	0		3.00
	TOTALS		0	40,788			
500.00	Grand Total: Decreases		1,813,677	11,934,669			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-7 Part I | Date/Time Prepared: 2/24/2022 4:28 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,419,368	600,335	0	600,335	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	57,618,245	1,843,484	0	1,843,484	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	20,351,820	1,738,017	0	1,738,017	2,660,420	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	79,389,433	4,181,836	0	4,181,836	2,660,420	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	79,389,433	4,181,836	0	4,181,836	2,660,420	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,019,703	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	59,461,729	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	19,429,417	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	80,910,849	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	80,910,849	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-7 Part II Date/Time Prepared: 2/24/2022 4:28 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	5,009,776	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,051,543	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,009,776	2,051,543	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	5,009,776		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,051,543		2.00
3.00	Total (sum of lines 1-2)	0	7,061,319		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-7 Part III Date/Time Prepared: 2/24/2022 4:28 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	61,481,432	0	61,481,432	0.759866	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	19,429,417	0	19,429,417	0.240134	0	2.00
3.00	Total (sum of lines 1-2)	80,910,849	0	80,910,849	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	3,636,845	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,212,557	2,051,543	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,849,402	2,051,543	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	907,419	73,097	26,321	0	4,643,682	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	14,306	0	0	3,278,406	2.00
3.00	Total (sum of lines 1-2)	907,419	87,403	26,321	0	7,922,088	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-8 | Date/Time Prepared: 2/24/2022 4:28 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-575,439	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-3,102	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	A	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)	B	-16,617	ADMINISTRATIVE & GENERAL	5.00	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	-4,310,990			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	-405,575			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-171,959	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	B	-8,320	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-723	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	-4,381	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	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant	A	-178,133	CLINIC- ORTHO	90.01	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-8 | Date/Time Prepared: 2/24/2022 4:28 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	LOBBYING EXPENSES	A	-5,320	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MEALS ON WHEELS	B	-6,688	DIETARY	10.00	0	33.01
33.02	RENTAL INCOME OFFSET - CANCER CENTER	B	-32,168	ONCOLOGY	76.01	0	33.02
33.03	ATM SURCHARGE REVENUE	B	-24,129	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	RHC OB PHYSICIAN & MIDLEVELS OFFSET	A	-429,611	RURAL HEALTH CLINIC III	88.02	0	33.04
33.05	HAF EXPENSE	A	-2,552,155	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PHYSICIAN RECRUITMENT	A	-29,400	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PHYSICIAN RECRUITMENT	A	-31,094	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	PEDS/ENT MIDLEVELS OFFSET	A	-148,017	CLINIC - PEDS, ENT, FP	90.02	0	33.08
33.09	PSYCH MIDLEVELS OFFSET	A	-212,389	PSYCHIATRY	90.04	0	33.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,146,210				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-8-1 | Date/Time Prepared: 2/24/2022 4:28 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	CMO AND MOB RENTAL	848,360	987,272	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO EXPENSE - CAMERON WOODS	0	207,002	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	CMO EXPENSE - CAMERON WOODS	0	26,850	3.00
3.01	14.00	CENTRAL SERVICES & SUPPLY	CMO EXPENSE - CAMERON WOODS	0	3,300	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	CMO EXPENSE - CAMERON WOODS	0	3,450	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO EXPENSE - RETAIL PHARMAC	0	26,061	4.01
5.00	0		0	848,360	1,253,935	5.00

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

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

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

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

6.00	C	CAMERON MEDICAL	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet A-8-1 Date/Time Prepared: 2/24/2022 4:28 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-138,912	9		1.00
2.00	-207,002	0		2.00
3.00	-26,850	0		3.00
3.01	-3,300	0		3.01
4.00	-3,450	0		4.00
4.01	-26,061	0		4.01
5.00	-405,575			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-8-2 | Date/Time Prepared: 2/24/2022 4:28 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	15.00	PHARMACY	740	740	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	758,554	758,554	0	0	0	2.00
3.00	50.00	OPERATING ROOM	693,012	693,012	0	0	0	3.00
4.00	60.00	LABORATORY	7,563	2,521	5,042	0	0	4.00
5.00	90.01	CLINIC- ORTHO	858,746	821,246	37,500	0	0	5.00
6.00	90.02	CLINIC - PEDS, ENT, FP	1,021,597	1,021,597	0	0	0	6.00
7.00	90.04	PSYCHIATRY	434,674	434,674	0	0	0	7.00
8.00	90.05	CARDIOLOGY	578,646	578,646	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			4,353,532	4,310,990	42,542		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	15.00	PHARMACY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	90.01	CLINIC- ORTHO	0	0	0	0	0	5.00
6.00	90.02	CLINIC - PEDS, ENT, FP	0	0	0	0	0	6.00
7.00	90.04	PSYCHIATRY	0	0	0	0	0	7.00
8.00	90.05	CARDIOLOGY	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	15.00	PHARMACY	0	0	0	740		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	758,554		2.00
3.00	50.00	OPERATING ROOM	0	0	0	693,012		3.00
4.00	60.00	LABORATORY	0	0	0	2,521		4.00
5.00	90.01	CLINIC- ORTHO	0	0	0	821,246		5.00
6.00	90.02	CLINIC - PEDS, ENT, FP	0	0	0	1,021,597		6.00
7.00	90.04	PSYCHIATRY	0	0	0	434,674		7.00
8.00	90.05	CARDIOLOGY	0	0	0	578,646		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	4,310,990		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part I | Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,643,682	4,643,682				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,278,406		3,278,406			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,936,299	38,036	22,475	9,996,810		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,999,098	450,739	323,818	1,775,308	13,548,963	5.00
7.00	00700	OPERATION OF PLANT	4,686,491	455,980	210,838	333,423	5,686,732	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	48,546	47,974	22,182	0	118,702	8.00
9.00	00900	HOUSEKEEPING	1,520,379	8,131	3,760	276,692	1,808,962	9.00
10.00	01000	DIETARY	331,877	183,359	84,782	63,116	663,134	10.00
11.00	01100	CAFETERIA	392,132	89,669	41,462	105,975	629,238	11.00
13.00	01300	NURSING ADMINISTRATION	647,369	29,814	36,511	188,279	901,973	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	434,034	140,760	65,085	70,378	710,257	14.00
15.00	01500	PHARMACY	1,492,187	52,175	24,125	270,257	1,838,744	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	683,132	0	23,122	185,309	891,563	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,449,571	764,196	353,351	951,438	5,518,556	30.00
31.00	03100	INTENSIVE CARE UNIT	75,058	53,305	24,647	21,244	174,254	31.00
43.00	04300	NURSERY	12,053	18,973	8,773	3,345	43,144	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,673,794	496,093	229,386	279,147	2,678,420	50.00
51.00	05100	RECOVERY ROOM	725,308	321,047	148,447	227,996	1,422,798	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	752,221	158,558	73,315	209,733	1,193,827	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,959,152	379,862	175,642	618,773	4,133,429	54.00
60.00	06000	LABORATORY	3,337,473	125,311	57,942	330,775	3,851,501	60.00
65.00	06500	RESPIRATORY THERAPY	1,007,443	32,977	15,248	291,866	1,347,534	65.00
65.01	06501	SLEEP LAB	75,814	0	54,307	12,808	142,929	65.01
66.00	06600	PHYSICAL THERAPY	1,065,006	280,391	129,648	328,038	1,803,083	66.00
69.00	06900	ELECTROCARDIOLOGY	158,945	17,030	7,875	27,158	211,008	69.00
69.01	06901	CARDIAC REHABILITATION	61,350	28,459	13,159	17,275	120,243	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	951,912	0	0	0	951,912	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,829,666	0	0	0	1,829,666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	921,972	0	0	0	921,972	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	1,416,211	0	231,850	0	1,648,061	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,157,889	0	141,805	349,993	1,649,687	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,728,988	0	136,374	493,630	2,358,992	88.01
88.02	08802	RURAL HEALTH CLINIC III	776,937	0	73,022	341,802	1,191,761	88.02
90.00	09000	CLINIC	151,725	3,027	10,402	41,556	206,710	90.00
90.01	09001	CLINIC- ORTHO	241,259	0	83,048	115,196	439,503	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	95,704	0	124,907	371,833	592,444	90.02
90.03	09003	INTRAVENOUS THERAPY	2,921,153	23,716	10,966	26,040	2,981,875	90.03
90.04	09004	PSYCHIATRY	34,632	0	36,908	210,119	281,659	90.04
90.05	09005	CARDIOLOGY	145,435	0	30,746	217,430	393,611	90.05
91.00	09100	EMERGENCY	2,255,721	411,936	190,472	618,325	3,476,454	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,076,024	4,611,518	3,220,400	9,374,257	68,363,301	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,201	12,115	0	38,316	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,110	0	2,110	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	3,049	0	0	0	3,049	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	1,115,118	0	21,243	72,210	1,208,571	194.05
194.06	07956	GUEST MEALS	61,399	0	0	11,446	72,845	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	129,862	0	0	40,191	170,053	194.12

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part I Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.13	07963	OCCUPATIONAL HEALTH	347,889	0	17,692	73,265	438,846	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	368,858	5,963	4,846	47,608	427,275	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	745,940	0	0	192,760	938,700	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	624,780	0	0	185,073	809,853	194.17
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	72,472,919	4,643,682	3,278,406	9,996,810	72,472,919	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part I | Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,548,963					5.00
7.00	00700	OPERATION OF PLANT	1,307,593	6,994,325				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,294	57,014	203,010			8.00
9.00	00900	HOUSEKEEPING	415,953	9,663	42,010	2,276,588		9.00
10.00	01000	DIETARY	152,481	217,910	18	50,122	1,083,665	10.00
11.00	01100	CAFETERIA	144,687	106,566	10	24,543	0	11.00
13.00	01300	NURSING ADMINISTRATION	207,400	93,842	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	163,316	167,284	0	18,666	0	14.00
15.00	01500	PHARMACY	422,801	62,007	0	20,049	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	205,006	59,430	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,268,937	908,200	53,641	744,574	1,055,420	30.00
31.00	03100	INTENSIVE CARE UNIT	40,068	63,349	1,275	10,370	28,245	31.00
43.00	04300	NURSERY	9,921	22,548	2,070	27,999	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	615,876	589,576	16,800	177,675	0	50.00
51.00	05100	RECOVERY ROOM	327,158	381,544	10,871	115,108	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	274,509	188,437	2,867	36,987	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	950,441	451,442	18,678	147,601	0	54.00
60.00	06000	LABORATORY	885,614	148,924	383	89,874	0	60.00
65.00	06500	RESPIRATORY THERAPY	309,852	39,191	153	25,234	0	65.00
65.01	06501	SLEEP LAB	32,865	139,583	2,159	27,999	0	65.01
66.00	06600	PHYSICAL THERAPY	414,601	333,227	3,703	83,307	0	66.00
69.00	06900	ELECTROCARDIOLOGY	48,519	20,239	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	27,649	33,822	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	218,883	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	420,713	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	211,998	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	378,955	595,911	1,137	346	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	379,329	364,472	2,412	88,837	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	542,427	350,513	2,760	1,037	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	274,034	187,685	49	5,531	0	88.02
90.00	09000	CLINIC	47,531	26,735	5	16,247	0	90.00
90.01	09001	CLINIC- ORTHO	101,059	213,454	1,158	75,011	0	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	136,227	321,040	36	51,851	0	90.02
90.03	09003	INTRAVENOUS THERAPY	685,652	28,185	2,116	22,469	0	90.03
90.04	09004	PSYCHIATRY	64,765	94,863	368	346	0	90.04
90.05	09005	CARDIOLOGY	90,507	79,025	3	13,827	0	90.05
91.00	09100	EMERGENCY	799,376	489,559	36,766	393,028	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,603,997	6,845,240	201,448	2,268,638	1,083,665	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,810	31,138	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	485	5,422	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	701	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	277,899	54,598	0	0	0	194.05
194.06	07956	GUEST MEALS	16,750	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	39,102	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	100,908	45,472	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	98,248	12,455	0	0	0	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	215,845	0	997	7,950	0	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	186,218	0	565	0	0	194.17

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part I Date/Time Prepared: 2/24/2022 4:28 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
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)	13,548,963	6,994,325	203,010	2,276,588	1,083,665	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part I | Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	905,044					11.00
13.00	01300	NURSING ADMINISTRATION	50,847	1,254,062				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,866	0	1,078,389			14.00
15.00	01500	PHARMACY	16,915	0	4,844	2,365,360		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	43,280	0	988	0	1,200,267	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	154,221	514,428	36,666	0	7,663	30.00
31.00	03100	INTENSIVE CARE UNIT	3,527	11,773	0	0	281	31.00
43.00	04300	NURSERY	479	1,587	0	0	21	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	47,183	157,441	96,774	0	22,911	50.00
51.00	05100	RECOVERY ROOM	33,350	111,248	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,755	99,310	15,618	0	1,169	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	95,565	0	19,208	0	201,096	54.00
60.00	06000	LABORATORY	72,521	0	213,226	0	329,874	60.00
65.00	06500	RESPIRATORY THERAPY	43,588	0	11,369	0	14,784	65.00
65.01	06501	SLEEP LAB	2,910	0	0	0	7,392	65.01
66.00	06600	PHYSICAL THERAPY	52,696	0	2,586	0	87,221	66.00
69.00	06900	ELECTROCARDIOLOGY	4,486	0	797	0	56,657	69.00
69.01	06901	CARDIAC REHABILITATION	3,527	0	336	0	22,415	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	201,419	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	387,148	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	591,103	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	2,361	0	75,232	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	18,562	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	29,173	0	2,303	0	45,235	88.02
90.00	09000	CLINIC	9,039	30,136	3,711	0	3,073	90.00
90.01	09001	CLINIC- ORTHO	18,284	0	2,519	0	28,325	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	27,735	0	2,595	0	48,925	90.02
90.03	09003	INTRAVENOUS THERAPY	4,520	0	3,267	1,774,257	0	90.03
90.04	09004	PSYCHIATRY	18,798	0	189	0	32,642	90.04
90.05	09005	CARDIOLOGY	11,436	0	523	0	5,159	90.05
91.00	09100	EMERGENCY	98,373	328,139	38,107	0	128,328	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	891,074	1,254,062	1,065,116	2,365,360	1,118,403	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	10,649	0	194	0	0	194.05
194.06	07956	GUEST MEALS	3,321	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	424	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	1,182	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	0	0	0	0	0	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	10,112	0	54,810	194.16

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part I Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	0	1,361	0	27,054	194.17
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)	905,044	1,254,062	1,078,389	2,365,360	1,200,267	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part I | Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	10,262,306	0	10,262,306		30.00
31.00	03100	INTENSIVE CARE UNIT	333,142	0	333,142		31.00
43.00	04300	NURSERY	107,769	0	107,769		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,402,656	0	4,402,656		50.00
51.00	05100	RECOVERY ROOM	2,402,077	0	2,402,077		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,842,479	0	1,842,479		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,017,460	0	6,017,460		54.00
60.00	06000	LABORATORY	5,591,917	0	5,591,917		60.00
65.00	06500	RESPIRATORY THERAPY	1,791,705	0	1,791,705		65.00
65.01	06501	SLEEP LAB	355,837	0	355,837		65.01
66.00	06600	PHYSICAL THERAPY	2,780,424	0	2,780,424		66.00
69.00	06900	ELECTROCARDIOLOGY	341,706	0	341,706		69.00
69.01	06901	CARDIAC REHABILITATION	207,992	0	207,992		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,372,214	0	1,372,214		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,637,527	0	2,637,527		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,725,073	0	1,725,073		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0		76.00
76.01	03480	ONCOLOGY	2,624,410	0	2,624,410		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,562,330	0	2,562,330		88.00
88.01	08801	RURAL HEALTH CLINIC II	3,274,291	0	3,274,291		88.01
88.02	08802	RURAL HEALTH CLINIC III	1,735,771	0	1,735,771		88.02
90.00	09000	CLINIC	343,187	0	343,187		90.00
90.01	09001	CLINIC- ORTHO	879,313	0	879,313		90.01
90.02	09002	CLINIC - PEDS, ENT, FP	1,180,853	0	1,180,853		90.02
90.03	09003	INTRAVENOUS THERAPY	5,502,341	0	5,502,341		90.03
90.04	09004	PSYCHIATRY	493,630	0	493,630		90.04
90.05	09005	CARDIOLOGY	594,091	0	594,091		90.05
91.00	09100	EMERGENCY	5,788,130	0	5,788,130		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,150,631	0	67,150,631		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	78,264	0	78,264		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,017	0	8,017		192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0		194.00
194.01	07951	MOB	0	0	0		194.01
194.02	07952	COMMUNITY HEALTH	3,750	0	3,750		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0		194.03
194.04	07954	EDUCATION	0	0	0		194.04
194.05	07955	MARKETING	1,551,911	0	1,551,911		194.05
194.06	07956	GUEST MEALS	92,916	0	92,916		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0		194.08
194.09	07959	URGENT CARE	0	0	0		194.09
194.10	07960	RHC	0	0	0		194.10
194.11	07961	OBGYN	0	0	0		194.11
194.12	07962	TRINE STUDENT HEALTH	209,579	0	209,579		194.12
194.13	07963	OCCUPATIONAL HEALTH	586,408	0	586,408		194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0		194.14

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part I Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.15	07965	FOUNDATION	537,978	0	537,978		194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	1,228,414	0	1,228,414		194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	1,025,051	0	1,025,051		194.17
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	72,472,919	0	72,472,919		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part II | Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	38,036	22,475	60,511	60,511	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	450,739	323,818	774,557	10,739	5.00
7.00	00700	OPERATION OF PLANT	0	455,980	210,838	666,818	2,019	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	47,974	22,182	70,156	0	8.00
9.00	00900	HOUSEKEEPING	0	8,131	3,760	11,891	1,675	9.00
10.00	01000	DIETARY	0	183,359	84,782	268,141	382	10.00
11.00	01100	CAFETERIA	0	89,669	41,462	131,131	642	11.00
13.00	01300	NURSING ADMINISTRATION	0	29,814	36,511	66,325	1,140	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	140,760	65,085	205,845	426	14.00
15.00	01500	PHARMACY	0	52,175	24,125	76,300	1,636	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	23,122	23,122	1,122	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	764,196	353,351	1,117,547	5,760	30.00
31.00	03100	INTENSIVE CARE UNIT	0	53,305	24,647	77,952	129	31.00
43.00	04300	NURSERY	0	18,973	8,773	27,746	20	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	496,093	229,386	725,479	1,690	50.00
51.00	05100	RECOVERY ROOM	0	321,047	148,447	469,494	1,380	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	158,558	73,315	231,873	1,270	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	379,862	175,642	555,504	3,746	54.00
60.00	06000	LABORATORY	0	125,311	57,942	183,253	2,002	60.00
65.00	06500	RESPIRATORY THERAPY	0	32,977	15,248	48,225	1,767	65.00
65.01	06501	SLEEP LAB	0	0	54,307	54,307	78	65.01
66.00	06600	PHYSICAL THERAPY	0	280,391	129,648	410,039	1,986	66.00
69.00	06900	ELECTROCARDIOLOGY	0	17,030	7,875	24,905	164	69.00
69.01	06901	CARDIAC REHABILITATION	0	28,459	13,159	41,618	105	69.01
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
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	231,850	231,850	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	141,805	141,805	2,119	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	136,374	136,374	2,988	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	73,022	73,022	2,069	88.02
90.00	09000	CLINIC	0	3,027	10,402	13,429	252	90.00
90.01	09001	CLINIC- ORTHO	0	0	83,048	83,048	697	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	0	0	124,907	124,907	2,251	90.02
90.03	09003	INTRAVENOUS THERAPY	0	23,716	10,966	34,682	158	90.03
90.04	09004	PSYCHIATRY	0	0	36,908	36,908	1,272	90.04
90.05	09005	CARDIOLOGY	0	0	30,746	30,746	1,316	90.05
91.00	09100	EMERGENCY	0	411,936	190,472	602,408	3,743	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,611,518	3,220,400	7,831,918	56,743	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,201	12,115	38,316	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,110	2,110	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	0	21,243	21,243	437	194.05
194.06	07956	GUEST MEALS	0	0	0	0	69	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	0	0	243	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	17,692	17,692	444	194.13

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part II Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	0	5,963	4,846	10,809	288	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	0	0	1,167	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	0	0	0	1,120	194.17
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,643,682	3,278,406	7,922,088	60,511	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part II Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	785,296					5.00
7.00	00700	OPERATION OF PLANT	75,800	744,637				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,582	6,070	77,808			8.00
9.00	00900	HOUSEKEEPING	24,108	1,029	16,101	54,804		9.00
10.00	01000	DIETARY	8,838	23,199	7	1,207	301,774	10.00
11.00	01100	CAFETERIA	8,386	11,345	4	591	0	11.00
13.00	01300	NURSING ADMINISTRATION	12,021	9,991	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,466	17,810	0	449	0	14.00
15.00	01500	PHARMACY	24,505	6,601	0	483	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,882	6,327	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	73,546	96,690	20,557	17,925	293,908	30.00
31.00	03100	INTENSIVE CARE UNIT	2,322	6,744	489	250	7,866	31.00
43.00	04300	NURSERY	575	2,401	793	674	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,695	62,768	6,439	4,277	0	50.00
51.00	05100	RECOVERY ROOM	18,962	40,620	4,167	2,771	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,910	20,062	1,099	890	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,086	48,062	7,159	3,553	0	54.00
60.00	06000	LABORATORY	51,329	15,855	147	2,164	0	60.00
65.00	06500	RESPIRATORY THERAPY	17,959	4,172	59	607	0	65.00
65.01	06501	SLEEP LAB	1,905	14,860	828	674	0	65.01
66.00	06600	PHYSICAL THERAPY	24,030	35,476	1,419	2,005	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,812	2,155	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	1,602	3,601	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,686	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,384	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,287	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	21,964	63,442	436	8	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	21,985	38,803	925	2,139	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	31,438	37,317	1,058	25	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	15,883	19,982	19	133	0	88.02
90.00	09000	CLINIC	2,755	2,846	2	391	0	90.00
90.01	09001	CLINIC- ORTHO	5,857	22,725	444	1,806	0	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	7,896	34,179	14	1,248	0	90.02
90.03	09003	INTRAVENOUS THERAPY	39,739	3,001	811	541	0	90.03
90.04	09004	PSYCHIATRY	3,754	10,099	141	8	0	90.04
90.05	09005	CARDIOLOGY	5,246	8,413	1	333	0	90.05
91.00	09100	EMERGENCY	46,331	52,120	14,091	9,461	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	730,526	728,765	77,210	54,613	301,774	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	511	3,315	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28	577	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	41	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	16,107	5,813	0	0	0	194.05
194.06	07956	GUEST MEALS	971	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	2,266	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	5,849	4,841	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	5,694	1,326	0	0	0	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	12,510	0	382	191	0	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	10,793	0	216	0	0	194.17

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part II Date/Time Prepared: 2/24/2022 4:28 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
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)	785,296	744,637	77,808	54,804	301,774	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part II Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	152,099					11.00
13.00	01300	NURSING ADMINISTRATION	8,545	98,022				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,171	0	237,167			14.00
15.00	01500	PHARMACY	2,843	0	1,065	113,433		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,273	0	217	0	49,943	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,916	40,209	8,064	0	319	30.00
31.00	03100	INTENSIVE CARE UNIT	593	920	0	0	12	31.00
43.00	04300	NURSERY	81	124	0	0	1	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,929	12,306	21,283	0	953	50.00
51.00	05100	RECOVERY ROOM	5,605	8,696	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,001	7,762	3,435	0	49	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,060	0	4,224	0	8,368	54.00
60.00	06000	LABORATORY	12,188	0	46,894	0	13,723	60.00
65.00	06500	RESPIRATORY THERAPY	7,325	0	2,500	0	615	65.00
65.01	06501	SLEEP LAB	489	0	0	0	308	65.01
66.00	06600	PHYSICAL THERAPY	8,856	0	569	0	3,629	66.00
69.00	06900	ELECTROCARDIOLOGY	754	0	175	0	2,358	69.00
69.01	06901	CARDIAC REHABILITATION	593	0	74	0	933	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	44,297	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	85,146	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	28,347	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	519	0	3,130	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	4,082	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	4,903	0	507	0	1,882	88.02
90.00	09000	CLINIC	1,519	2,356	816	0	128	90.00
90.01	09001	CLINIC- ORTHO	3,073	0	554	0	1,179	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	4,661	0	571	0	2,036	90.02
90.03	09003	INTRAVENOUS THERAPY	760	0	719	85,086	0	90.03
90.04	09004	PSYCHIATRY	3,159	0	41	0	1,358	90.04
90.05	09005	CARDIOLOGY	1,922	0	115	0	215	90.05
91.00	09100	EMERGENCY	16,532	25,649	8,381	0	5,340	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	149,751	98,022	234,248	113,433	46,536	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	1,790	0	43	0	0	194.05
194.06	07956	GUEST MEALS	558	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	93	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	260	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	0	0	0	0	0	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	2,224	0	2,281	194.16

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part II Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	0	299	0	1,126	194.17
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)	152,099	98,022	237,167	113,433	49,943	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part II | Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,700,441	0	1,700,441		30.00
31.00	03100	INTENSIVE CARE UNIT	97,277	0	97,277		31.00
43.00	04300	NURSERY	32,415	0	32,415		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	878,819	0	878,819		50.00
51.00	05100	RECOVERY ROOM	551,695	0	551,695		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	287,351	0	287,351		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	701,762	0	701,762		54.00
60.00	06000	LABORATORY	327,555	0	327,555		60.00
65.00	06500	RESPIRATORY THERAPY	83,229	0	83,229		65.00
65.01	06501	SLEEP LAB	73,449	0	73,449		65.01
66.00	06600	PHYSICAL THERAPY	488,009	0	488,009		66.00
69.00	06900	ELECTROCARDIOLOGY	33,323	0	33,323		69.00
69.01	06901	CARDIAC REHABILITATION	48,526	0	48,526		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	56,983	0	56,983		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	109,530	0	109,530		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,634	0	40,634		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0		76.00
76.01	03480	ONCOLOGY	317,700	0	317,700		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	211,425	0	211,425		88.00
88.01	08801	RURAL HEALTH CLINIC II	213,282	0	213,282		88.01
88.02	08802	RURAL HEALTH CLINIC III	118,400	0	118,400		88.02
90.00	09000	CLINIC	24,494	0	24,494		90.00
90.01	09001	CLINIC- ORTHO	119,383	0	119,383		90.01
90.02	09002	CLINIC - PEDS, ENT, FP	177,763	0	177,763		90.02
90.03	09003	INTRAVENOUS THERAPY	165,497	0	165,497		90.03
90.04	09004	PSYCHIATRY	56,740	0	56,740		90.04
90.05	09005	CARDIOLOGY	48,307	0	48,307		90.05
91.00	09100	EMERGENCY	784,056	0	784,056		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,748,045	0	7,748,045		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	42,142	0	42,142		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,715	0	2,715		192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0		194.00
194.01	07951	MOB	0	0	0		194.01
194.02	07952	COMMUNITY HEALTH	41	0	41		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0		194.03
194.04	07954	EDUCATION	0	0	0		194.04
194.05	07955	MARKETING	45,433	0	45,433		194.05
194.06	07956	GUEST MEALS	1,598	0	1,598		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0		194.08
194.09	07959	URGENT CARE	0	0	0		194.09
194.10	07960	RHC	0	0	0		194.10
194.11	07961	OBGYN	0	0	0		194.11
194.12	07962	TRINE STUDENT HEALTH	2,602	0	2,602		194.12
194.13	07963	OCCUPATIONAL HEALTH	29,086	0	29,086		194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0		194.14

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part II Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.15	07965	FOUNDATION	18,117	0	18,117		194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	18,755	0	18,755		194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	13,554	0	13,554		194.17
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	7,922,088	0	7,922,088		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B-1 | Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	102,797					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		156,956				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	842	1,076	31,802,166			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,978	15,503	5,647,682	-13,548,963	58,923,956	5.00
7.00	00700	OPERATION OF PLANT	10,094	10,094	1,060,694	0	5,686,732	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	1,062	0	0	118,702	8.00
9.00	00900	HOUSEKEEPING	180	180	880,221	0	1,808,962	9.00
10.00	01000	DIETARY	4,059	4,059	200,785	0	663,134	10.00
11.00	01100	CAFETERIA	1,985	1,985	337,131	0	629,238	11.00
13.00	01300	NURSING ADMINISTRATION	660	1,748	598,958	0	901,973	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,116	3,116	223,889	0	710,257	14.00
15.00	01500	PHARMACY	1,155	1,155	859,749	0	1,838,744	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,107	589,511	0	891,563	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,917	16,917	3,026,742	0	5,518,556	30.00
31.00	03100	INTENSIVE CARE UNIT	1,180	1,180	67,583	0	174,254	31.00
43.00	04300	NURSERY	420	420	10,641	0	43,144	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,982	10,982	888,029	0	2,678,420	50.00
51.00	05100	RECOVERY ROOM	7,107	7,107	725,308	0	1,422,798	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,510	3,510	667,210	0	1,193,827	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,409	8,409	1,968,458	0	4,133,429	54.00
60.00	06000	LABORATORY	2,774	2,774	1,052,270	0	3,851,501	60.00
65.00	06500	RESPIRATORY THERAPY	730	730	928,492	0	1,347,534	65.00
65.01	06501	SLEEP LAB	0	2,600	40,745	0	142,929	65.01
66.00	06600	PHYSICAL THERAPY	6,207	6,207	1,043,565	0	1,803,083	66.00
69.00	06900	ELECTROCARDIOLOGY	377	377	86,397	0	211,008	69.00
69.01	06901	CARDIAC REHABILITATION	630	630	54,957	0	120,243	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	951,912	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,829,666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	921,972	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	11,100	0	0	1,648,061	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,789	1,113,407	0	1,649,687	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	6,529	1,570,351	0	2,358,992	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	3,496	1,087,351	0	1,191,761	88.02
90.00	09000	CLINIC	67	498	132,200	0	206,710	90.00
90.01	09001	CLINIC- ORTHO	0	3,976	366,464	0	439,503	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	0	5,980	1,182,886	0	592,444	90.02
90.03	09003	INTRAVENOUS THERAPY	525	525	82,840	0	2,981,875	90.03
90.04	09004	PSYCHIATRY	0	1,767	668,436	0	281,659	90.04
90.05	09005	CARDIOLOGY	0	1,472	691,694	0	393,611	90.05
91.00	09100	EMERGENCY	9,119	9,119	1,967,034	0	3,476,454	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	102,085	154,179	29,821,680	-13,548,963	54,814,338	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	580	580	0	0	38,316	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	101	0	0	2,110	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	3,049	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	1,017	229,717	0	1,208,571	194.05
194.06	07956	GUEST MEALS	0	0	36,413	0	72,845	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	127,857	0	170,053	194.12

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B-1 | Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
194.13	07963	OCCUPATIONAL HEALTH	0	847	233,073	0	438,846	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	132	232	151,452	0	427,275	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	613,213	0	938,700	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	0	588,761	0	809,853	194.17
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,643,682	3,278,406	9,996,810		13,548,963	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	45.173322	20.887421	0.314344		0.229940	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			60,511		785,296	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001903		0.013327	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: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B-1 | Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	130,283					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	79,441				8.00
9.00	00900	HOUSEKEEPING	180	16,439	6,586			9.00
10.00	01000	DIETARY	4,059	7	145	16,651		10.00
11.00	01100	CAFETERIA	1,985	4	71	0	26,432	11.00
13.00	01300	NURSING ADMINISTRATION	1,748	0	0	0	1,485	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,116	0	54	0	551	14.00
15.00	01500	PHARMACY	1,155	0	58	0	494	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,107	0	0	0	1,264	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,917	20,991	2,154	16,217	4,504	30.00
31.00	03100	INTENSIVE CARE UNIT	1,180	499	30	434	103	31.00
43.00	04300	NURSERY	420	810	81	0	14	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,982	6,574	514	0	1,378	50.00
51.00	05100	RECOVERY ROOM	7,107	4,254	333	0	974	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,510	1,122	107	0	869	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,409	7,309	427	0	2,791	54.00
60.00	06000	LABORATORY	2,774	150	260	0	2,118	60.00
65.00	06500	RESPIRATORY THERAPY	730	60	73	0	1,273	65.00
65.01	06501	SLEEP LAB	2,600	845	81	0	85	65.01
66.00	06600	PHYSICAL THERAPY	6,207	1,449	241	0	1,539	66.00
69.00	06900	ELECTROCARDIOLOGY	377	0	0	0	131	69.00
69.01	06901	CARDIAC REHABILITATION	630	0	0	0	103	69.01
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
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	11,100	445	1	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,789	944	257	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,529	1,080	3	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,496	19	16	0	852	88.02
90.00	09000	CLINIC	498	2	47	0	264	90.00
90.01	09001	CLINIC- ORTHO	3,976	453	217	0	534	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	5,980	14	150	0	810	90.02
90.03	09003	INTRAVENOUS THERAPY	525	828	65	0	132	90.03
90.04	09004	PSYCHIATRY	1,767	144	1	0	549	90.04
90.05	09005	CARDIOLOGY	1,472	1	40	0	334	90.05
91.00	09100	EMERGENCY	9,119	14,387	1,137	0	2,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	127,506	78,830	6,563	16,651	26,024	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	580	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	101	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	1,017	0	0	0	311	194.05
194.06	07956	GUEST MEALS	0	0	0	0	97	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	847	0	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	232	0	0	0	0	194.15

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B-1 | Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	390	23	0	0	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	221	0	0	0	194.17
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,994,325	203,010	2,276,588	1,083,665	905,044	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	53.685631	2.555481	345.670817	65.081076	34.240466	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	744,637	77,808	54,804	301,774	152,099	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.715535	0.979444	8.321288	18.123476	5.754351	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: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B-1 | Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	228,372					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,096,493				14.00
15.00	01500	PHARMACY	0	22,895	10,000			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,669	0	624,481		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	93,680	173,284	0	3,987		30.00
31.00	03100	INTENSIVE CARE UNIT	2,144	0	0	146		31.00
43.00	04300	NURSERY	289	0	0	11		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,671	457,357	0	11,920		50.00
51.00	05100	RECOVERY ROOM	20,259	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,085	73,811	0	608		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	90,776	0	104,627		54.00
60.00	06000	LABORATORY	0	1,007,714	0	171,629		60.00
65.00	06500	RESPIRATORY THERAPY	0	53,728	0	7,692		65.00
65.01	06501	SLEEP LAB	0	0	0	3,846		65.01
66.00	06600	PHYSICAL THERAPY	0	12,223	0	45,380		66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,769	0	29,478		69.00
69.01	06901	CARDIAC REHABILITATION	0	1,586	0	11,662		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	951,912	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,829,666	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,499	0		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0		76.00
76.01	03480	ONCOLOGY	0	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	11,160	0	39,142		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	87,724	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	10,885	0	23,535		88.02
90.00	09000	CLINIC	5,488	17,536	0	1,599		90.00
90.01	09001	CLINIC- ORTHO	0	11,904	0	14,737		90.01
90.02	09002	CLINIC - PEDS, ENT, FP	0	12,262	0	25,455		90.02
90.03	09003	INTRAVENOUS THERAPY	0	15,442	7,501	0		90.03
90.04	09004	PSYCHIATRY	0	891	0	16,983		90.04
90.05	09005	CARDIOLOGY	0	2,472	0	2,684		90.05
91.00	09100	EMERGENCY	59,756	180,094	0	66,767		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	228,372	5,033,760	10,000	581,888		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0		194.00
194.01	07951	MOB	0	0	0	0		194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0		194.03
194.04	07954	EDUCATION	0	0	0	0		194.04
194.05	07955	MARKETING	0	916	0	0		194.05
194.06	07956	GUEST MEALS	0	0	0	0		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0	0		194.08
194.09	07959	URGENT CARE	0	0	0	0		194.09
194.10	07960	RHC	0	0	0	0		194.10
194.11	07961	OBGYN	0	0	0	0		194.11
194.12	07962	TRINE STUDENT HEALTH	0	2,005	0	0		194.12
194.13	07963	OCCUPATIONAL HEALTH	0	5,588	0	0		194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0		194.14

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B-1 | Date/Time Prepared: 2/24/2022 4:28 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
194.15	07965	FOUNDATION	0	0	0	0		194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	47,791	0	28,517		194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	6,433	0	14,076		194.17
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)	1,254,062	1,078,389	2,365,360	1,200,267		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.491312	0.211594	236.536000	1.922023		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	98,022	237,167	113,433	49,943		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.429221	0.046535	11.343300	0.079975		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: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part I Date/Time Prepared: 2/24/2022 4:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,262,306		10,262,306	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	333,142		333,142	0	0	31.00
43.00	04300	NURSERY	107,769		107,769	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,402,656		4,402,656	0	0	50.00
51.00	05100	RECOVERY ROOM	2,402,077		2,402,077	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,842,479		1,842,479	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,017,460		6,017,460	0	0	54.00
60.00	06000	LABORATORY	5,591,917		5,591,917	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,791,705	0	1,791,705	0	0	65.00
65.01	06501	SLEEP LAB	355,837	0	355,837	0	0	65.01
66.00	06600	PHYSICAL THERAPY	2,780,424	0	2,780,424	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	341,706		341,706	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	207,992		207,992	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,372,214		1,372,214	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,637,527		2,637,527	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,725,073		1,725,073	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0		0	0	0	76.00
76.01	03480	ONCOLOGY	2,624,410		2,624,410	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,562,330		2,562,330	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,274,291		3,274,291	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,735,771		1,735,771	0	0	88.02
90.00	09000	CLINIC	343,187		343,187	0	0	90.00
90.01	09001	CLINIC- ORTHO	879,313		879,313	0	0	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	1,180,853		1,180,853	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	5,502,341		5,502,341	0	0	90.03
90.04	09004	PSYCHIATRY	493,630		493,630	0	0	90.04
90.05	09005	CARDIOLOGY	594,091		594,091	0	0	90.05
91.00	09100	EMERGENCY	5,788,130		5,788,130	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,668,681		2,668,681		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	69,819,312	0	69,819,312	0	0	200.00
201.00		Less Observation Beds	2,668,681		2,668,681		0	201.00
202.00		Total (see instructions)	67,150,631	0	67,150,631	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part I Date/Time Prepared: 2/24/2022 4:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,367,577		7,367,577			30.00
31.00	03100	INTENSIVE CARE UNIT	374,500		374,500			31.00
43.00	04300	NURSERY	424,000		424,000			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,715,362	19,127,792	21,843,154	0.201558	0.000000	50.00
51.00	05100	RECOVERY ROOM	629,942	3,756,274	4,386,216	0.547642	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,725,068	415,516	2,140,584	0.860737	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,159,169	38,520,112	40,679,281	0.147924	0.000000	54.00
60.00	06000	LABORATORY	3,775,222	22,696,318	26,471,540	0.211243	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,174,543	1,016,042	3,190,585	0.561560	0.000000	65.00
65.01	06501	SLEEP LAB	0	1,108,271	1,108,271	0.321074	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,176,410	4,222,784	5,399,194	0.514970	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	713,705	2,678,362	3,392,067	0.100737	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	419	449,597	450,016	0.462188	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	454,353	2,815,771	3,270,124	0.419621	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	405,417	2,745,748	3,151,165	0.837001	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,398,460	5,860,135	9,258,595	0.186321	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0.000000	0.000000	76.00
76.01	03480	ONCOLOGY	0	15,164,630	15,164,630	0.173061	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	12,768	1,715,270	1,728,038			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,530,770	2,530,770			88.01
88.02	08802	RURAL HEALTH CLINIC III	630,687	1,143,001	1,773,688			88.02
90.00	09000	CLINIC	0	591,561	591,561	0.580138	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	93,494	93,494	9.405021	0.000000	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	0	575,278	575,278	2.052665	0.000000	90.02
90.03	09003	INTRAVENOUS THERAPY	0	9,905,539	9,905,539	0.555481	0.000000	90.03
90.04	09004	PSYCHIATRY	0	138,696	138,696	3.559079	0.000000	90.04
90.05	09005	CARDIOLOGY	0	20,769	20,769	28.604699	0.000000	90.05
91.00	09100	EMERGENCY	648,628	26,793,754	27,442,382	0.210919	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	74,043	3,818,344	3,892,387	0.685616	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	28,860,273	167,903,828	196,764,101			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	28,860,273	167,903,828	196,764,101			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part I Date/Time Prepared: 2/24/2022 4:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
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
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
65.01	06501	SLEEP LAB	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHABILITATION	0.000000		69.01
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
76.00	03020	CHEMICAL DEPENDENCY	0.000000		76.00
76.01	03480	ONCOLOGY	0.000000		76.01
		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
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC- ORTHO	0.000000		90.01
90.02	09002	CLINIC - PEDS, ENT, FP	0.000000		90.02
90.03	09003	INTRAVENOUS THERAPY	0.000000		90.03
90.04	09004	PSYCHIATRY	0.000000		90.04
90.05	09005	CARDIOLOGY	0.000000		90.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part I Date/Time Prepared: 2/24/2022 4:28 pm

Title XIX | Hospital | PPS

		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	10,262,306		10,262,306	0	10,262,306	30.00
31.00	03100	INTENSIVE CARE UNIT	333,142		333,142	0	333,142	31.00
43.00	04300	NURSERY	107,769		107,769	0	107,769	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,402,656		4,402,656	0	4,402,656	50.00
51.00	05100	RECOVERY ROOM	2,402,077		2,402,077	0	2,402,077	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,842,479		1,842,479	0	1,842,479	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,017,460		6,017,460	0	6,017,460	54.00
60.00	06000	LABORATORY	5,591,917		5,591,917	0	5,591,917	60.00
65.00	06500	RESPIRATORY THERAPY	1,791,705	0	1,791,705	0	1,791,705	65.00
65.01	06501	SLEEP LAB	355,837	0	355,837	0	355,837	65.01
66.00	06600	PHYSICAL THERAPY	2,780,424	0	2,780,424	0	2,780,424	66.00
69.00	06900	ELECTROCARDIOLOGY	341,706		341,706	0	341,706	69.00
69.01	06901	CARDIAC REHABILITATION	207,992		207,992	0	207,992	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,372,214		1,372,214	0	1,372,214	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,637,527		2,637,527	0	2,637,527	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,725,073		1,725,073	0	1,725,073	73.00
76.00	03020	CHEMICAL DEPENDENCY	0		0	0	0	76.00
76.01	03480	ONCOLOGY	2,624,410		2,624,410	0	2,624,410	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,562,330		2,562,330	0	2,562,330	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,274,291		3,274,291	0	3,274,291	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,735,771		1,735,771	0	1,735,771	88.02
90.00	09000	CLINIC	343,187		343,187	0	343,187	90.00
90.01	09001	CLINIC- ORTHO	879,313		879,313	0	879,313	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	1,180,853		1,180,853	0	1,180,853	90.02
90.03	09003	INTRAVENOUS THERAPY	5,502,341		5,502,341	0	5,502,341	90.03
90.04	09004	PSYCHIATRY	493,630		493,630	0	493,630	90.04
90.05	09005	CARDIOLOGY	594,091		594,091	0	594,091	90.05
91.00	09100	EMERGENCY	5,788,130		5,788,130	0	5,788,130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,668,681		2,668,681		2,668,681	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	69,819,312	0	69,819,312	0	69,819,312	200.00
201.00		Less Observation Beds	2,668,681		2,668,681		2,668,681	201.00
202.00		Total (see instructions)	67,150,631	0	67,150,631	0	67,150,631	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part I Date/Time Prepared: 2/24/2022 4:28 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,367,577		7,367,577			30.00
31.00	03100	INTENSIVE CARE UNIT	374,500		374,500			31.00
43.00	04300	NURSERY	424,000		424,000			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,715,362	19,127,792	21,843,154	0.201558	0.000000	50.00
51.00	05100	RECOVERY ROOM	629,942	3,756,274	4,386,216	0.547642	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,725,068	415,516	2,140,584	0.860737	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,159,169	38,520,112	40,679,281	0.147924	0.000000	54.00
60.00	06000	LABORATORY	3,775,222	22,696,318	26,471,540	0.211243	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,174,543	1,016,042	3,190,585	0.561560	0.000000	65.00
65.01	06501	SLEEP LAB	0	1,108,271	1,108,271	0.321074	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,176,410	4,222,784	5,399,194	0.514970	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	713,705	2,678,362	3,392,067	0.100737	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	419	449,597	450,016	0.462188	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	454,353	2,815,771	3,270,124	0.419621	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	405,417	2,745,748	3,151,165	0.837001	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,398,460	5,860,135	9,258,595	0.186321	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0.000000	0.000000	76.00
76.01	03480	ONCOLOGY	0	15,164,630	15,164,630	0.173061	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	12,768	1,715,270	1,728,038	1.482797	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,530,770	2,530,770	1.293792	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	630,687	1,143,001	1,773,688	0.978623	0.000000	88.02
90.00	09000	CLINIC	0	591,561	591,561	0.580138	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	93,494	93,494	9.405021	0.000000	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	0	575,278	575,278	2.052665	0.000000	90.02
90.03	09003	INTRAVENOUS THERAPY	0	9,905,539	9,905,539	0.555481	0.000000	90.03
90.04	09004	PSYCHIATRY	0	138,696	138,696	3.559079	0.000000	90.04
90.05	09005	CARDIOLOGY	0	20,769	20,769	28.604699	0.000000	90.05
91.00	09100	EMERGENCY	648,628	26,793,754	27,442,382	0.210919	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	74,043	3,818,344	3,892,387	0.685616	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	28,860,273	167,903,828	196,764,101			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	28,860,273	167,903,828	196,764,101			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part I Date/Time Prepared: 2/24/2022 4:28 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.201558		50.00
51.00	05100	RECOVERY ROOM	0.547642		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.860737		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147924		54.00
60.00	06000	LABORATORY	0.211243		60.00
65.00	06500	RESPIRATORY THERAPY	0.561560		65.00
65.01	06501	SLEEP LAB	0.321074		65.01
66.00	06600	PHYSICAL THERAPY	0.514970		66.00
69.00	06900	ELECTROCARDIOLOGY	0.100737		69.00
69.01	06901	CARDIAC REHABILITATION	0.462188		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.419621		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.837001		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.186321		73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000		76.00
76.01	03480	ONCOLOGY	0.173061		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1.482797		88.00
88.01	08801	RURAL HEALTH CLINIC II	1.293792		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.978623		88.02
90.00	09000	CLINIC	0.580138		90.00
90.01	09001	CLINIC- ORTHO	9.405021		90.01
90.02	09002	CLINIC - PEDS, ENT, FP	2.052665		90.02
90.03	09003	INTRAVENOUS THERAPY	0.555481		90.03
90.04	09004	PSYCHIATRY	3.559079		90.04
90.05	09005	CARDIOLOGY	28.604699		90.05
91.00	09100	EMERGENCY	0.210919		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.685616		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part II Date/Time Prepared: 2/24/2022 4:28 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,402,656	878,819	3,523,837	0	0	50.00
51.00	05100	RECOVERY ROOM	2,402,077	551,695	1,850,382	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,842,479	287,351	1,555,128	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,017,460	701,762	5,315,698	0	0	54.00
60.00	06000	LABORATORY	5,591,917	327,555	5,264,362	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,791,705	83,229	1,708,476	0	0	65.00
65.01	06501	SLEEP LAB	355,837	73,449	282,388	0	0	65.01
66.00	06600	PHYSICAL THERAPY	2,780,424	488,009	2,292,415	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	341,706	33,323	308,383	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	207,992	48,526	159,466	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,372,214	56,983	1,315,231	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,637,527	109,530	2,527,997	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,725,073	40,634	1,684,439	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	2,624,410	317,700	2,306,710	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,562,330	211,425	2,350,905	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,274,291	213,282	3,061,009	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,735,771	118,400	1,617,371	0	0	88.02
90.00	09000	CLINIC	343,187	24,494	318,693	0	0	90.00
90.01	09001	CLINIC- ORTHO	879,313	119,383	759,930	0	0	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	1,180,853	177,763	1,003,090	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	5,502,341	165,497	5,336,844	0	0	90.03
90.04	09004	PSYCHIATRY	493,630	56,740	436,890	0	0	90.04
90.05	09005	CARDIOLOGY	594,091	48,307	545,784	0	0	90.05
91.00	09100	EMERGENCY	5,788,130	784,056	5,004,074	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,668,681	442,195	2,226,486	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	59,116,095	6,360,107	52,755,988	0	0	200.00
201.00		Less Observation Beds	2,668,681	442,195	2,226,486	0	0	201.00
202.00		Total (line 200 minus line 201)	56,447,414	5,917,912	50,529,502	0	0	202.00

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

Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part II Date/Time Prepared: 2/24/2022 4:28 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,402,656	21,843,154	0.201558		50.00
51.00	05100	RECOVERY ROOM	2,402,077	4,386,216	0.547642		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,842,479	2,140,584	0.860737		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,017,460	40,679,281	0.147924		54.00
60.00	06000	LABORATORY	5,591,917	26,471,540	0.211243		60.00
65.00	06500	RESPIRATORY THERAPY	1,791,705	3,190,585	0.561560		65.00
65.01	06501	SLEEP LAB	355,837	1,108,271	0.321074		65.01
66.00	06600	PHYSICAL THERAPY	2,780,424	5,399,194	0.514970		66.00
69.00	06900	ELECTROCARDIOLOGY	341,706	3,392,067	0.100737		69.00
69.01	06901	CARDIAC REHABILITATION	207,992	450,016	0.462188		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,372,214	3,270,124	0.419621		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,637,527	3,151,165	0.837001		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,725,073	9,258,595	0.186321		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0.000000		76.00
76.01	03480	ONCOLOGY	2,624,410	15,164,630	0.173061		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,562,330	1,728,038	1.482797		88.00
88.01	08801	RURAL HEALTH CLINIC II	3,274,291	2,530,770	1.293792		88.01
88.02	08802	RURAL HEALTH CLINIC III	1,735,771	1,773,688	0.978623		88.02
90.00	09000	CLINIC	343,187	591,561	0.580138		90.00
90.01	09001	CLINIC- ORTHO	879,313	93,494	9.405021		90.01
90.02	09002	CLINIC - PEDS, ENT, FP	1,180,853	575,278	2.052665		90.02
90.03	09003	INTRAVENOUS THERAPY	5,502,341	9,905,539	0.555481		90.03
90.04	09004	PSYCHIATRY	493,630	138,696	3.559079		90.04
90.05	09005	CARDIOLOGY	594,091	20,769	28.604699		90.05
91.00	09100	EMERGENCY	5,788,130	27,442,382	0.210919		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,668,681	3,892,387	0.685616		92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	0	0.000000		116.00
200.00		Subtotal (sum of lines 50 thru 199)	59,116,095	188,598,024			200.00
201.00		Less Observation Beds	2,668,681	0			201.00
202.00		Total (line 200 minus line 201)	56,447,414	188,598,024			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part II Date/Time Prepared: 2/24/2022 4:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	878,819	21,843,154	0.040233	606,005	24,381	50.00
51.00	05100	RECOVERY ROOM	551,695	4,386,216	0.125779	103,969	13,077	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	287,351	2,140,584	0.134240	450	60	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	701,762	40,679,281	0.017251	478,710	8,258	54.00
60.00	06000	LABORATORY	327,555	26,471,540	0.012374	842,734	10,428	60.00
65.00	06500	RESPIRATORY THERAPY	83,229	3,190,585	0.026086	426,934	11,137	65.00
65.01	06501	SLEEP LAB	73,449	1,108,271	0.066274	0	0	65.01
66.00	06600	PHYSICAL THERAPY	488,009	5,399,194	0.090386	142,329	12,865	66.00
69.00	06900	ELECTROCARDIOLOGY	33,323	3,392,067	0.009824	212,405	2,087	69.00
69.01	06901	CARDIAC REHABILITATION	48,526	450,016	0.107832	419	45	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	56,983	3,270,124	0.017425	287,747	5,014	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	109,530	3,151,165	0.034759	122,884	4,271	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,634	9,258,595	0.004389	729,847	3,203	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	317,700	15,164,630	0.020950	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	211,425	1,728,038	0.122350	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	213,282	2,530,770	0.084276	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	118,400	1,773,688	0.066754	0	0	88.02
90.00	09000	CLINIC	24,494	591,561	0.041406	0	0	90.00
90.01	09001	CLINIC- ORTHO	119,383	93,494	1.276905	0	0	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	177,763	575,278	0.309004	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	165,497	9,905,539	0.016708	0	0	90.03
90.04	09004	PSYCHIATRY	56,740	138,696	0.409096	0	0	90.04
90.05	09005	CARDIOLOGY	48,307	20,769	2.325918	0	0	90.05
91.00	09100	EMERGENCY	784,056	27,442,382	0.028571	51,773	1,479	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	442,195	3,892,387	0.113605	16,548	1,880	92.00
200.00		Total (lines 50 through 199)	6,360,107	188,598,024		4,022,754	98,185	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part IV Date/Time Prepared: 2/24/2022 4:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
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
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		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
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	0	0	0	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0	0	0	0	0	90.03
90.04	09004	PSYCHIATRY	0	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
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: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part IV Date/Time Prepared: 2/24/2022 4:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	21,843,154	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,386,216	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,140,584	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	40,679,281	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	26,471,540	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,190,585	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	1,108,271	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	5,399,194	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,392,067	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	450,016	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,270,124	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,151,165	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,258,595	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	15,164,630	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,728,038	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,530,770	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,773,688	0.000000	88.02
90.00	09000	CLINIC	0	0	0	591,561	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	93,494	0.000000	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	0	0	0	575,278	0.000000	90.02
90.03	09003	INTRAVENOUS THERAPY	0	0	0	9,905,539	0.000000	90.03
90.04	09004	PSYCHIATRY	0	0	0	138,696	0.000000	90.04
90.05	09005	CARDIOLOGY	0	0	0	20,769	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	27,442,382	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,892,387	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	188,598,024		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part IV Date/Time Prepared: 2/24/2022 4:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	606,005	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	103,969	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	450	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	478,710	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	842,734	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	426,934	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	142,329	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	212,405	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	419	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	287,747	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	122,884	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	729,847	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	0	0	0	76.01
		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
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	0.000000	0	0	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.000000	0	0	0	0	90.03
90.04	09004	PSYCHIATRY	0.000000	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	51,773	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	16,548	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,022,754	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part V Date/Time Prepared: 2/24/2022 4:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.201558	0	3,468,157	0	0	50.00
51.00	05100	RECOVERY ROOM	0.547642	0	498,165	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.860737	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147924	0	8,026,981	0	0	54.00
60.00	06000	LABORATORY	0.211243	0	4,561,045	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.561560	0	228,464	0	0	65.00
65.01	06501	SLEEP LAB	0.321074	0	188,820	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.514970	0	1,152,657	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.100737	0	567,485	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.462188	0	141,399	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.419621	0	388,021	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.837001	0	503,042	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.186321	0	309,528	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.173061	0	5,555,902	0	0	76.01
		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
90.00	09000	CLINIC	0.580138	0	216,161	0	0	90.00
90.01	09001	CLINIC- ORTHO	9.405021	0	44,204	0	0	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	2.052665	0	55,768	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.555481	0	6,548,936	4,326	0	90.03
90.04	09004	PSYCHIATRY	3.559079	0	32,444	0	0	90.04
90.05	09005	CARDIOLOGY	28.604699	0	9,843	0	0	90.05
91.00	09100	EMERGENCY	0.210919	0	4,490,854	84,290	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.685616	0	1,027,121	0	0	92.00
200.00		Subtotal (see instructions)		0	38,014,997	88,616	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	38,014,997	88,616	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part V Date/Time Prepared: 2/24/2022 4:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	699,035	0		50.00
51.00	05100	RECOVERY ROOM	272,816	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,187,383	0		54.00
60.00	06000	LABORATORY	963,489	0		60.00
65.00	06500	RESPIRATORY THERAPY	128,296	0		65.00
65.01	06501	SLEEP LAB	60,625	0		65.01
66.00	06600	PHYSICAL THERAPY	593,584	0		66.00
69.00	06900	ELECTROCARDIOLOGY	57,167	0		69.00
69.01	06901	CARDIAC REHABILITATION	65,353	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	162,822	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	421,047	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,672	0		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0		76.00
76.01	03480	ONCOLOGY	961,510	0		76.01
		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
90.00	09000	CLINIC	125,403	0		90.00
90.01	09001	CLINIC- ORTHO	415,740	0		90.01
90.02	09002	CLINIC - PEDS, ENT, FP	114,473	0		90.02
90.03	09003	INTRAVENOUS THERAPY	3,637,810	2,403		90.03
90.04	09004	PSYCHIATRY	115,471	0		90.04
90.05	09005	CARDIOLOGY	281,556	0		90.05
91.00	09100	EMERGENCY	947,206	17,778		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	704,211	0		92.00
200.00		Subtotal (see instructions)	11,972,669	20,181		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	11,972,669	20,181		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part I Date/Time Prepared: 2/24/2022 4:28 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,700,441	222,669	1,477,772	4,682	315.63	30.00
31.00	INTENSIVE CARE UNIT	97,277		97,277	126	772.04	31.00
43.00	NURSERY	32,415		32,415	426	76.09	43.00
200.00	Total (lines 30 through 199)	1,830,133		1,607,464	5,234		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	23	7,259	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
43.00	NURSERY	7	533	43.00
200.00	Total (lines 30 through 199)	30	7,792	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part II Date/Time Prepared: 2/24/2022 4:28 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	878,819	21,843,154	0.040233	8,054	324	50.00
51.00	05100	RECOVERY ROOM	551,695	4,386,216	0.125779	4,194	528	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	287,351	2,140,584	0.134240	52,374	7,031	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	701,762	40,679,281	0.017251	11,653	201	54.00
60.00	06000	LABORATORY	327,555	26,471,540	0.012374	23,404	290	60.00
65.00	06500	RESPIRATORY THERAPY	83,229	3,190,585	0.026086	10,559	275	65.00
65.01	06501	SLEEP LAB	73,449	1,108,271	0.066274	0	0	65.01
66.00	06600	PHYSICAL THERAPY	488,009	5,399,194	0.090386	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	33,323	3,392,067	0.009824	1,219	12	69.00
69.01	06901	CARDIAC REHABILITATION	48,526	450,016	0.107832	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	56,983	3,270,124	0.017425	4,945	86	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	109,530	3,151,165	0.034759	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,634	9,258,595	0.004389	21,084	93	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	317,700	15,164,630	0.020950	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	211,425	1,728,038	0.122350	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	213,282	2,530,770	0.084276	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	118,400	1,773,688	0.066754	0	0	88.02
90.00	09000	CLINIC	24,494	591,561	0.041406	0	0	90.00
90.01	09001	CLINIC- ORTHO	119,383	93,494	1.276905	0	0	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	177,763	575,278	0.309004	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	165,497	9,905,539	0.016708	0	0	90.03
90.04	09004	PSYCHIATRY	56,740	138,696	0.409096	0	0	90.04
90.05	09005	CARDIOLOGY	48,307	20,769	2.325918	0	0	90.05
91.00	09100	EMERGENCY	784,056	27,442,382	0.028571	7,141	204	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	442,195	3,892,387	0.113605	700	80	92.00
200.00		Total (lines 50 through 199)	6,360,107	188,598,024		145,327	9,124	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part III Date/Time Prepared: 2/24/2022 4:28 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,682	0.00	23	30.00
31.00	03100	INTENSIVE CARE UNIT		0	126	0.00	0	31.00
43.00	04300	NURSERY		0	426	0.00	7	43.00
200.00		Total (lines 30 through 199)		0	5,234		30	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part IV Date/Time Prepared: 2/24/2022 4:28 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	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
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
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
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
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		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
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	0	0	0	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0	0	0	0	0	90.03
90.04	09004	PSYCHIATRY	0	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
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: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part IV | Date/Time Prepared: 2/24/2022 4:28 pm

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		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	21,843,154	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,386,216	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,140,584	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	40,679,281	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	26,471,540	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,190,585	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	1,108,271	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	5,399,194	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,392,067	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	450,016	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,270,124	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,151,165	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,258,595	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	15,164,630	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,728,038	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,530,770	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,773,688	0.000000	88.02
90.00	09000	CLINIC	0	0	0	591,561	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	93,494	0.000000	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	0	0	0	575,278	0.000000	90.02
90.03	09003	INTRAVENOUS THERAPY	0	0	0	9,905,539	0.000000	90.03
90.04	09004	PSYCHIATRY	0	0	0	138,696	0.000000	90.04
90.05	09005	CARDIOLOGY	0	0	0	20,769	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	27,442,382	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,892,387	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	188,598,024		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part IV | Date/Time Prepared: 2/24/2022 4:28 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	8,054	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	4,194	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52,374	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	11,653	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	23,404	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	10,559	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,219	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,945	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	21,084	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	0	0	0	76.01
		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
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	0.000000	0	0	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.000000	0	0	0	0	90.03
90.04	09004	PSYCHIATRY	0.000000	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	7,141	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	700	0	0	0	92.00
200.00		Total (lines 50 through 199)		145,327	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-1 | Date/Time Prepared: 2/24/2022 4:28 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,107	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,682	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)	3,281	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	123	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)	490	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	177	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)	635	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	840	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)	101	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)	512	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)	10,262,306	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)	38,400	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)	137,763	25.00
26.00	Total swing-bed cost (see instructions)	1,343,830	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,918,476	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)	8,918,476	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)	1,904.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,600,066	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)	1,600,066	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-1 | Date/Time Prepared: 2/24/2022 4:28 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	333,142	126	2,643.98	52	137,487	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)	1,144,791	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,882,344	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)	192,389	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	975,278	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,167,667	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,401	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,904.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,668,681	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-1 | Date/Time Prepared: 2/24/2022 4:28 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,700,441	10,262,306	0.165698	2,668,681	442,195	90.00
91.00	Nursing Program cost	0	10,262,306	0.000000	2,668,681	0	91.00
92.00	Allied health cost	0	10,262,306	0.000000	2,668,681	0	92.00
93.00	All other Medical Education	0	10,262,306	0.000000	2,668,681	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-1 | Date/Time Prepared: 2/24/2022 4:28 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,107	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,682	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)	3,281	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	123	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)	490	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	177	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)	635	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	23	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	426	15.00
16.00	Nursery days (title V or XIX only)	7	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)	10,262,306	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)	38,400	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)	137,763	25.00
26.00	Total swing-bed cost (see instructions)	1,343,830	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,918,476	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)	8,918,476	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)	1,904.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	43,811	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)	43,811	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-1 | Date/Time Prepared: 2/24/2022 4:28 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	107,769	426	252.98	7	1,771	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	333,142	126	2,643.98	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)	69,710	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	115,292	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	7,792	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	9,124	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	16,916	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	98,376	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,401	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,904.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,668,681	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-1 | Date/Time Prepared: 2/24/2022 4:28 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,700,441	10,262,306	0.165698	2,668,681	442,195	90.00
91.00	Nursing Program cost	0	10,262,306	0.000000	2,668,681	0	91.00
92.00	Allied health cost	0	10,262,306	0.000000	2,668,681	0	92.00
93.00	All other Medical Education	0	10,262,306	0.000000	2,668,681	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-3 | Date/Time Prepared: 2/24/2022 4:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,300,450		30.00
31.00	03100	INTENSIVE CARE UNIT		156,000		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.201558	606,005	122,145	50.00
51.00	05100	RECOVERY ROOM	0.547642	103,969	56,938	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.860737	450	387	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147924	478,710	70,813	54.00
60.00	06000	LABORATORY	0.211243	842,734	178,022	60.00
65.00	06500	RESPIRATORY THERAPY	0.561560	426,934	239,749	65.00
65.01	06501	SLEEP LAB	0.321074	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.514970	142,329	73,295	66.00
69.00	06900	ELECTROCARDIOLOGY	0.100737	212,405	21,397	69.00
69.01	06901	CARDIAC REHABILITATION	0.462188	419	194	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.419621	287,747	120,745	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.837001	122,884	102,854	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.186321	729,847	135,986	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	0.173061	0	0	76.01
		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
90.00	09000	CLINIC	0.580138	0	0	90.00
90.01	09001	CLINIC- ORTHO	9.405021	0	0	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	2.052665	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.555481	0	0	90.03
90.04	09004	PSYCHIATRY	3.559079	0	0	90.04
90.05	09005	CARDIOLOGY	28.604699	0	0	90.05
91.00	09100	EMERGENCY	0.210919	51,773	10,920	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.685616	16,548	11,346	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,022,754	1,144,791	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)		4,022,754		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-3 | Date/Time Prepared: 2/24/2022 4:28 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.201558	0	0	50.00
51.00	05100	RECOVERY ROOM	0.547642	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.860737	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147924	84,303	12,470	54.00
60.00	06000	LABORATORY	0.211243	145,306	30,695	60.00
65.00	06500	RESPIRATORY THERAPY	0.561560	69,127	38,819	65.00
65.01	06501	SLEEP LAB	0.321074	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.514970	334,835	172,430	66.00
69.00	06900	ELECTROCARDIOLOGY	0.100737	19,015	1,916	69.00
69.01	06901	CARDIAC REHABILITATION	0.462188	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.419621	52,362	21,972	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.837001	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.186321	135,043	25,161	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	0.173061	0	0	76.01
		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
90.00	09000	CLINIC	0.580138	0	0	90.00
90.01	09001	CLINIC- ORTHO	9.405021	0	0	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	2.052665	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.555481	0	0	90.03
90.04	09004	PSYCHIATRY	3.559079	0	0	90.04
90.05	09005	CARDIOLOGY	28.604699	0	0	90.05
91.00	09100	EMERGENCY	0.210919	1,950	411	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.685616	2,965	2,033	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		844,906	305,907	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)		844,906		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-3 | Date/Time Prepared: 2/24/2022 4:28 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		19,968		30.00
31.00	03100	INTENSIVE CARE UNIT		3,431		31.00
43.00	04300	NURSERY		13,154		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.201558	8,054	1,623	50.00
51.00	05100	RECOVERY ROOM	0.547642	4,194	2,297	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.860737	52,374	45,080	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147924	11,653	1,724	54.00
60.00	06000	LABORATORY	0.211243	23,404	4,944	60.00
65.00	06500	RESPIRATORY THERAPY	0.561560	10,559	5,930	65.00
65.01	06501	SLEEP LAB	0.321074	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.514970	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.100737	1,219	123	69.00
69.01	06901	CARDIAC REHABILITATION	0.462188	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.419621	4,945	2,075	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.837001	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.186321	21,084	3,928	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	0.173061	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.482797	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.293792	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.978623	0	0	88.02
90.00	09000	CLINIC	0.580138	0	0	90.00
90.01	09001	CLINIC- ORTHO	9.405021	0	0	90.01
90.02	09002	CLINIC - PEDS, ENT, FP	2.052665	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.555481	0	0	90.03
90.04	09004	PSYCHIATRY	3.559079	0	0	90.04
90.05	09005	CARDIOLOGY	28.604699	0	0	90.05
91.00	09100	EMERGENCY	0.210919	7,141	1,506	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.685616	700	480	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		145,327	69,710	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)		145,327		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet E Part B Date/Time Prepared: 2/24/2022 4:28 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	11,992,850	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)	11,992,850	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)	12,112,779	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)	72,609	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	6,502,861	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)	5,537,309	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)	5,537,309	30.00
31.00	Primary payer payments	4,361	31.00
32.00	Subtotal (line 30 minus line 31)	5,532,948	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)	573,512	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	372,783	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	417,325	36.00
37.00	Subtotal (see instructions)	5,905,731	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)	5,905,731	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	6,111,744	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)	-206,013	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: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet E-1 Part I Date/Time Prepared: 2/24/2022 4:28 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,820,759		6,111,744	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	07/14/2021	323,800		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)		323,800		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)		3,144,559		6,111,744	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		487,386		206,013	6.02
7.00	Total Medicare program liability (see instructions)		2,657,173		5,905,731	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: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet E-1 Part I | Date/Time Prepared: 2/24/2022 4:28 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,567,850		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	07/14/2021	160,200		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)		160,200		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,728,050		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		249,015		0	6.02
7.00	Total Medicare program liability (see instructions)		1,479,035		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: 15-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet E-1 Part II Date/Time Prepared: 2/24/2022 4:28 pm
	Title XVIII	Hospital	Cost

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8 through 12, and 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 from S-3, Pt. I col. 8, sum of lines 1, 8 through 12, and 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: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet E-2 | Date/Time Prepared: 2/24/2022 4:28 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,179,344	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)	308,966	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	613	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)	1,488,310	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,488,310	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)	1,488,310	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	9,275	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,479,035	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)	1,479,035	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	1,728,050	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)	-249,015	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: 15-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part V Date/Time Prepared: 2/24/2022 4:28 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,882,344	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,882,344	4.00
5.00	Primary payer payments	23,961	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,887,206	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,887,206	19.00
20.00	Deductibles (exclude professional component)	248,100	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,639,106	22.00
23.00	Coinsurance	1,408	23.00
24.00	Subtotal (line 22 minus line 23)	2,637,698	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	29,961	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	19,475	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	16,139	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,657,173	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,657,173	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	3,144,559	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)	-487,386	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: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet E-3 Part VII Date/Time Prepared: 2/24/2022 4:28 pm

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	36,553		8.00
9.00	Ancillary service charges	145,327	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)	181,880	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)	181,880	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	181,880	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	126,306	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)	126,306	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)	126,306	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)	126,306	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	261	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)	126,045	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	126,045	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)	126,045	0	40.00
41.00	Interim payments	126,045	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	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: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet G | Date/Time Prepared: 2/24/2022 4:28 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	25,528,017	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	11,034,516	0	0	0	4.00
5.00	Other receivable	889,990	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,529,187	0	0	0	7.00
8.00	Prepaid expenses	890,001	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)	39,871,711	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,019,703	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	59,461,729	0	0	0	15.00
16.00	Accumulated depreciation	-28,215,380	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	19,429,417	0	0	0	23.00
24.00	Accumulated depreciation	-15,380,045	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)	37,315,424	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	30,433,600	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	1,016,678	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	31,450,278	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	108,637,413	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,922,951	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,461,032	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	8,315,942	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	951,567	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	18,651,492	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	40,957,959	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	40,957,959	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	59,609,451	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	49,027,962				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)	49,027,962	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	108,637,413	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet G-1 | Date/Time Prepared: 2/24/2022 4:28 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		35,298,814		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13,729,148				2.00
3.00	Total (sum of line 1 and line 2)		49,027,962		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)		49,027,962		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)		49,027,962		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: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/24/2022 4:28 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	8,345,453		8,345,453	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)	8,345,453		8,345,453	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	374,500		374,500	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)	374,500		374,500	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,719,953		8,719,953	17.00
18.00	Ancillary services	18,787,960	130,271,947	149,059,907	18.00
19.00	Outpatient services	703,857	32,247,888	32,951,745	19.00
20.00	RURAL HEALTH CLINIC	12,768	1,715,270	1,728,038	20.00
20.01	RURAL HEALTH CLINIC II	0	2,530,770	2,530,770	20.01
20.02	RURAL HEALTH CLINIC III	630,687	1,143,001	1,773,688	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	NON REIMBURSABLE	13,140	2,416,787	2,429,927	27.00
27.01	PROFESSIONAL FEES	176,650	3,402,564	3,579,214	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	29,045,015	173,728,227	202,773,242	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		81,619,129		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)		81,619,129		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2020 To 09/30/2021 | Worksheet G-3 | Date/Time Prepared: 2/24/2022 4:28 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	202,773,242	1.00
2.00	Less contractual allowances and discounts on patients' accounts	118,014,739	2.00
3.00	Net patient revenues (line 1 minus line 2)	84,758,503	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	81,619,129	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,139,374	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	279,311	6.00
7.00	Income from investments	4,748,167	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	1,273,961	24.00
24.01	CONTRIBUTIONS	0	24.01
24.02	GAIN/LOSS ON DISPOSAL OF PROPERTY	-6,046	24.02
24.50	COVID-19 PHE Funding	4,294,381	24.50
25.00	Total other income (sum of lines 6-24)	10,589,774	25.00
26.00	Total (line 5 plus line 25)	13,729,148	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	13,729,148	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-1 | Date/Time Prepared: 2/24/2022 4:28 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	416,521	2,353	418,874	0	418,874	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	233,559	0	233,559	0	233,559	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	315,143	0	315,143	0	315,143	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	17,998	0	17,998	0	17,998	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	42,188	0	42,188	0	42,188	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,025,409	2,353	1,027,762	0	1,027,762	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	8,257	8,257	0	8,257	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	8,257	8,257	0	8,257	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,025,409	10,610	1,036,019	0	1,036,019	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	209	209	0	209	29.00
30.00	Administrative Costs	87,997	33,664	121,661	0	121,661	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	87,997	33,873	121,870	0	121,870	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,113,406	44,483	1,157,889	0	1,157,889	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-1 | Date/Time Prepared: 2/24/2022 4:28 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	418,874		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	233,559		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	315,143		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	17,998		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	42,188		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,027,762		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	8,257		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	8,257		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,036,019		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	209		29.00
30.00	Administrative Costs	0	121,661		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	121,870		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,157,889		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-1 | Date/Time Prepared: 2/24/2022 4:28 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	511,113	60,903	572,016	0	572,016	1.00
2.00	Physician Assistant	138,922	0	138,922	0	138,922	2.00
3.00	Nurse Practitioner	273,651	0	273,651	0	273,651	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	228,768	0	228,768	0	228,768	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	178,959	0	178,959	0	178,959	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,331,413	60,903	1,392,316	0	1,392,316	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	83,696	83,696	0	83,696	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	83,696	83,696	0	83,696	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,331,413	144,599	1,476,012	0	1,476,012	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	962	962	0	962	29.00
30.00	Administrative Costs	238,938	13,076	252,014	0	252,014	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	238,938	14,038	252,976	0	252,976	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,570,351	158,637	1,728,988	0	1,728,988	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-1 | Date/Time Prepared: 2/24/2022 4:28 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	572,016		1.00
2.00	Physician Assistant	0	138,922		2.00
3.00	Nurse Practitioner	0	273,651		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	228,768		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	178,959		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,392,316		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	83,696		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	83,696		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,476,012		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	962		29.00
30.00	Administrative Costs	0	252,014		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	252,976		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,728,988		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-1 | Date/Time Prepared: 2/24/2022 4:28 pm

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	666,987	952	667,939	0	667,939	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	156,654	0	156,654	0	156,654	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	87,361	0	87,361	0	87,361	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	103,829	0	103,829	0	103,829	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,014,831	952	1,015,783	0	1,015,783	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	6,533	6,533	0	6,533	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	6,533	6,533	0	6,533	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,014,831	7,485	1,022,316	0	1,022,316	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	2,720	2,720	0	2,720	29.00
30.00	Administrative Costs	72,521	108,992	181,513	0	181,513	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	72,521	111,712	184,233	0	184,233	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,087,352	119,197	1,206,549	0	1,206,549	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-1 | Date/Time Prepared: 2/24/2022 4:28 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-347,902	320,037		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-81,710	74,944		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	87,361		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	103,829		9.00
10.00	Subtotal (sum of lines 1 through 9)	-429,612	586,171		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	6,533		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	6,533		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-429,612	592,704		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	2,720		29.00
30.00	Administrative Costs	0	181,513		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	184,233		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-429,612	776,937		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 Component CCN: 15-8530

Period: From 10/01/2020 To 09/30/2021

Worksheet M-2 Date/Time Prepared: 2/24/2022 4:28 pm

RHC I

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.68	3,646	4,200	2,856		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.56	5,318	2,100	3,276		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.24	8,964		6,132	8,964	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	0.28	90			90	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)	2.52	9,054			9,054	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)					1,036,019	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)					1,036,019	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)					121,870	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,404,441	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,526,311	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,526,311	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,526,311	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,562,330	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-2 | Date/Time Prepared: 2/24/2022 4:28 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.45	3,845	4,200	6,090		1.00
2.00	Physician Assistant	0.81	3,880	2,100	1,701		2.00
3.00	Nurse Practitioner	1.84	6,511	2,100	3,864		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.10	14,236		11,655	14,236	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)	4.10	14,236			14,236	8.00
9.00	Physician Services Under Agreements		388			388	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)					1,476,012	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)					1,476,012	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)					252,976	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,545,303	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,798,279	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,798,279	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,798,279	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,274,291	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-2 | Date/Time Prepared: 2/24/2022 4:28 pm

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.54	1,929	4,200	2,268		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.45	1,913	2,100	945		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.99	3,842		3,213	3,842	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)	0.99	3,842			3,842	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)					592,704	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)					592,704	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)					184,233	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					958,834	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,143,067	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,143,067	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,143,067	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,735,771	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1315 Component CCN: 15-8530	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/24/2022 4:28 pm
	Title XVIII	RHC I	Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	2,562,330	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	30,742	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	2,531,588	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	9,054	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)	9,054	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	279.61	7.00

		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	269.63	8.00
9.00	Rate for Program covered visits (see instructions)	279.61	279.61	269.63	9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	317	282	720	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	88,636	78,850	194,134	11.00
12.00	Program covered visits for mental health services (from contractor records)	1	2	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	280	559	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	280	559	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	362,459		16.00
16.01	Total program charges (see instructions)(from contractor's records)		224,943		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,517		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		10,501		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.)		259,308		16.04
16.05	Total program cost (see instructions)	0	269,809		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		27,823		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		38,122		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		269,809		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,685		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		276,494		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)		276,494		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		250,905		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)		25,589		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: 15-1315 Component CCN: 15-8545	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/24/2022 4:28 pm
	Title XVIII	RHC II	Cost

					1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)				3,274,291	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)				0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)				3,274,291	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)				14,236	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)				388	5.00
6.00	Total adjusted visits (line 4 plus line 5)				14,624	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)				223.90	7.00
		Calculation of Limit (1)				
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)		
		1.00	2.00	3.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	184.61		8.00
9.00	Rate for Program covered visits (see instructions)	223.90	223.90	184.61		9.00
	CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	197	155	647		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	44,108	34,705	119,443		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	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	198,256			16.00
16.01	Total program charges (see instructions)(from contractor's records)		171,025			16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		840			16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		974			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.)		141,602			16.04
16.05	Total program cost (see instructions)	0	142,576			16.05
17.00	Primary payer amounts		0			17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		20,279			18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		29,983			19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		142,576			20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0			21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		142,576			22.00
23.00	Allowable bad debts (see instructions)		28			23.00
23.01	Adjusted reimbursable bad debts (see instructions)		18			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)		142,594			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		118,019			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)		24,575			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: 15-1315 Component CCN: 15-8546	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/24/2022 4:28 pm
	Title XVIII	RHC III	Cost

					1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)				1,735,771	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)				0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)				1,735,771	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)				3,842	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)				3,842	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)				451.79	7.00
		Calculation of Limit (1)				
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)		
		1.00	2.00	3.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	303.92		8.00
9.00	Rate for Program covered visits (see instructions)	451.79	451.79	303.92		9.00
	CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	21	22	45		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	9,488	9,939	13,676		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	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	33,103			16.00
16.01	Total program charges (see instructions)(from contractor's records)		18,126			16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,225			16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,063			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.)		22,358			16.04
16.05	Total program cost (see instructions)	0	26,421			16.05
17.00	Primary payer amounts		0			17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,093			18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		2,962			19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		26,421			20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0			21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		26,421			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)		26,421			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		21,765			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)		4,656			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: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-4 | Date/Time Prepared: 2/24/2022 4:28 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,027,762	1,027,762	1,027,762	1,027,762	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000440	0.002148	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	452	2,208	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	5,343	4,427	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	5,795	6,635	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,036,019	1,036,019	1,036,019	1,036,019	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,526,311	1,526,311	1,526,311	1,526,311	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.005594	0.006404	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	8,538	9,774	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	14,333	16,409	0	0	10.00
11.00	Total number of injections/infusions (from your records)	51	249	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	281.04	65.90	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	13	46	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)	3,654	3,031	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)		30,742			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)		6,685			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1315 Component CCN: 15-8530	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/24/2022 4:28 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		250,905	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)		250,905	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		25,589	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		276,494	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: 15-1315 Component CCN: 15-8545	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/24/2022 4:28 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		118,019	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)		118,019	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		24,575	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		142,594	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: 15-1315 Component CCN: 15-8546	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/24/2022 4:28 pm
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		21,765	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)		21,765	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		4,656	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		26,421	7.00

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