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: 15-1324	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/27/2022 5:01 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/27/2022 Time: 5:01 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 FRANCISCAN HEALTH RENSSELAER (15-1324) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1				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				2
3	Signatory Title	CFO			3
4	Date				4

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-59,514	-2,298,440	0	-41	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	90,978	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		-3,394		0	10.00
10.01	BROOK RHC II	0		-40,944		0	10.01
200.00	Total	0	31,464	-2,342,778	0	-41	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: 15-1324	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 5:01 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1104 EAST GRACE STREET	PO Box:			1.00
2.00	City: RENSSELAER	State: IN	Zip Code: 47978	County: JASPER	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	FRANCISCAN HEALTH RENSSELAER	151324	23844	1	02/03/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	FRANCISCAN HEALTH RENSSELAER	15Z324	99915		12/31/2005	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	WHEATFIELD CLINIC	153990	99915		10/07/1999	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	BROOK	158502	99915		01/01/2005	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2021	12/31/2021	20.00
21.00	Type of Control (see instructions)	1		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.	0			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 5:01 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: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 5:01 pm

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

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

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

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1324	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 5:01 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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
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.	Y	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:	87,221	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.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	158014	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 5:01 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: FRANCISCAN ALLIANCE INC	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1515 W. DRAGOON TRAIL	PO Box: 1290		142.00
143.00	City: MISHAWAKA	State: IN	Zip Code: 46546-1290	143.00

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

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

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

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

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

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

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

		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: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2022 5:01 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	05/06/2022	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/08/2022	Y	04/08/2022	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II Date/Time Prepared: 5/27/2022 5:01 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	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.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	STEVE	HOWELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	FRANCISCAN ALLIANCE		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	765-428-5927	STEVEN.HOWELL@FRANCISCANALLIANCE.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1324	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/27/2022 5:01 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER COST REPORTING		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: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I Date/Time Prepared: 5/27/2022 5:01 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	21	7,665	29,472.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	29,472.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	196.00	0	8.00
9.00	CORONARY CARE UNIT	32.00	0	0	0.00	0	9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	29,668.00	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.)	115.00					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	BROOK RHC	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I Date/Time Prepared: 5/27/2022 5:01 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	626	31	1,228			1.00
2.00	HMO and other (see instructions)	271	103				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	506	0	506			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	365			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,132	31	2,099			7.00
8.00	INTENSIVE CARE UNIT	12	4	49			8.00
9.00	CORONARY CARE UNIT	0	0	0			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)	1,144	35	2,148	0.00	123.00	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.)				0.00	0.00	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	187	737	1,344	0.00	4.50	26.00
26.01	BROOK RHC	450	670	1,833	0.00	4.50	26.01
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	132.00	27.00
28.00	Observation Bed Days		162	601			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: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I Date/Time Prepared: 5/27/2022 5:01 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	227	52	453	1.00
2.00	HMO and other (see instructions)			0	0		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	227	52	453	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.)	0.00					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	BROOK RHC	0.00					26.01
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: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/27/2022 5:01 pm

RHC I | Cost

			1.00	
	Clinic Address and Identification			
1.00	Street		429 S BIERMA ST	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	WHEATFIELD	IN	47978	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 from	Sunday to	Monday from	Monday to	Tuesday from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	16:30	07:00	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 to	Wednesday from	Wednesday to	Thursday from	Thursday to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	07:00	16:30			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1324 Component CCN: 15-3990	Period: From 01/01/2021 To 12/31/2021	Worksheet S-8 Date/Time Prepared: 5/27/2022 5:01 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	16:30				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1324 Component CCN: 15-8502	Period: From 01/01/2021 To 12/31/2021	Worksheet S-8 Date/Time Prepared: 5/27/2022 5:01 pm
		RHC II	Cost

				1.00	
	Clinic Address and Identification				
1.00	Street			1104 E GRACE ST	1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	RENSSELAER	IN	47978	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			07:00	16:30	07:00	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	07:00	16:30	07:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1324 Component CCN: 15-8502	Period: From 01/01/2021 To 12/31/2021	Worksheet S-8 Date/Time Prepared: 5/27/2022 5:01 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						11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-10 | Date/Time Prepared: 5/27/2022 5:01 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)	0.359330	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	0	6.00
7.00	Medicaid cost (line 1 times line 6)	0	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)	0	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)	0	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)	0	0	0	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	0	0	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)	0	0	0	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)	1,279,199	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	493,811	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	759,709	27.01
28.00	Non-Medicare bad debt expense (see instructions)	519,490	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	452,566	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	452,566	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	452,566	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/27/2022 5:01 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		1,226,926	1,226,926	39,431	1,266,357	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,367,623	3,367,623	0	3,367,623	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,639,291	7,347,585	10,986,876	22,559	11,009,435	5.00
7.00	00700	OPERATION OF PLANT	303,478	1,084,658	1,388,136	0	1,388,136	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,297	55,719	82,016	0	82,016	8.00
9.00	00900	HOUSEKEEPING	377,917	109,003	486,920	-36,802	450,118	9.00
10.00	01000	DIETARY	241,528	134,034	375,562	-241,535	134,027	10.00
11.00	01100	CAFETERIA	0	0	0	241,535	241,535	11.00
13.00	01300	NURSING ADMINISTRATION	210,279	134,377	344,656	0	344,656	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	32,254	134,888	167,142	0	167,142	14.00
15.00	01500	PHARMACY	317,885	2,756,019	3,073,904	-2,684,438	389,466	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	388	0	388	0	388	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,797,581	75,590	1,873,171	-280	1,872,891	30.00
31.00	03100	INTENSIVE CARE UNIT	512,792	1,062	513,854	0	513,854	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	679,308	459,624	1,138,932	34,055	1,172,987	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	933,536	459,397	1,392,933	-19,979	1,372,954	54.00
60.00	06000	LABORATORY	0	2,256,430	2,256,430	-284	2,256,146	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	6,200	6,200	0	6,200	63.00
65.00	06500	RESPIRATORY THERAPY	673,435	56,146	729,581	0	729,581	65.00
66.00	06600	PHYSICAL THERAPY	493,852	30,357	524,209	-150	524,059	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	440,562	34,312	474,874	-303	474,571	66.01
67.00	06700	OCCUPATIONAL THERAPY	89,892	5,186	95,078	0	95,078	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	107,946	1,795	109,741	0	109,741	67.01
68.00	06800	SPEECH PATHOLOGY	93,708	1,012	94,720	0	94,720	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	107,979	2,195	110,174	0	110,174	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	632,299	632,299	0	632,299	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	193,163	193,163	0	193,163	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,677,219	2,677,219	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	277,833	131,837	409,670	-12,438	397,232	88.00
88.01	08801	BROOK RHC	311,027	106,007	417,034	-16,030	401,004	88.01
90.00	09000	CLINIC	811,757	321,684	1,133,441	-55	1,133,386	90.00
90.01	09001	WOUND CARE	27,491	84,374	111,865	-2,071	109,794	90.01
91.00	09100	EMERGENCY	1,134,192	1,000,037	2,134,229	-434	2,133,795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,642,208	22,209,539	35,851,747	0	35,851,747	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,042	2,042	0	2,042	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ALTERNACARE	36,124	457	36,581	0	36,581	194.00
194.01	07951	SPORTS MEDICINE	31,025	540	31,565	0	31,565	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	100	2,456	2,556	0	2,556	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	13,709,457	22,215,034	35,924,491	0	35,924,491	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/27/2022 5:01 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	316,995	1,583,352	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-712,932	2,654,691	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,702,167	9,307,268	5.00
7.00	00700	OPERATION OF PLANT	-6,954	1,381,182	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	82,016	8.00
9.00	00900	HOUSEKEEPING	0	450,118	9.00
10.00	01000	DIETARY	0	134,027	10.00
11.00	01100	CAFETERIA	-52,626	188,909	11.00
13.00	01300	NURSING ADMINISTRATION	228,899	573,555	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-77,191	89,951	14.00
15.00	01500	PHARMACY	54,756	444,222	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	458,348	458,736	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-503,110	1,369,781	30.00
31.00	03100	INTENSIVE CARE UNIT	0	513,854	31.00
32.00	03200	CORONARY CARE UNIT	0	0	32.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-161,373	1,011,614	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-10,191	1,362,763	54.00
60.00	06000	LABORATORY	0	2,256,146	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	6,200	63.00
65.00	06500	RESPIRATORY THERAPY	-14,996	714,585	65.00
66.00	06600	PHYSICAL THERAPY	0	524,059	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	474,571	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	95,078	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	109,741	67.01
68.00	06800	SPEECH PATHOLOGY	0	94,720	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	110,174	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	632,299	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	193,163	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,677,219	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	-61,483	335,749	88.00
88.01	08801	BROOK RHC	-53,362	347,642	88.01
90.00	09000	CLINIC	-225,000	908,386	90.00
90.01	09001	WOUND CARE	-81,000	28,794	90.01
91.00	09100	EMERGENCY	0	2,133,795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,603,387	33,248,360	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,042	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	ALTERNACARE	0	36,581	194.00
194.01	07951	SPORTS MEDICINE	0	31,565	194.01
194.02	07952	UNUSED SPACE	0	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	2,556	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,603,387	33,321,104	200.00

RECLASSIFICATIONS | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/27/2022 5:01 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	155,334	86,201	1.00
	TOTALS		155,334	86,201	
	B - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	39,431	1.00
	TOTALS		0	39,431	
	C - HOUSEKEEPING				
1.00	OPERATING ROOM	50.00	36,802	0	1.00
	TOTALS		36,802	0	
	D - DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,677,219	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	61,990	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	TOTALS		0	2,739,209	
500.00	Grand Total: Increases		192,136	2,864,841	500.00

RECLASSIFICATIONS | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/27/2022 5:01 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA					
1.00	DIETARY	10.00	155,334	86,201	0	1.00
	TOTALS		155,334	86,201		
	B - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	39,431	12	1.00
	TOTALS		0	39,431		
	C - HOUSEKEEPING					
1.00	HOUSEKEEPING	9.00	36,802	0	0	1.00
	TOTALS		36,802	0		
	D - DRUGS					
1.00		0.00	0	0	0	1.00
2.00	PHARMACY	15.00	0	2,684,438	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	280	0	3.00
4.00	OPERATING ROOM	50.00	0	2,747	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	19,979	0	5.00
6.00	LABORATORY	60.00	0	284	0	6.00
7.00	PHYSICAL THERAPY	66.00	0	150	0	7.00
8.00	PHYSICAL THERAPY- WHEATFIELD	66.01	0	303	0	8.00
9.00	RURAL HEALTH CLINIC	88.00	0	12,438	0	9.00
10.00	BROOK RHC	88.01	0	16,030	0	10.00
11.00	CLINIC	90.00	0	55	0	11.00
12.00	WOUND CARE	90.01	0	2,071	0	12.00
13.00	EMERGENCY	91.00	0	434	0	13.00
	TOTALS		0	2,739,209		
500.00	Grand Total: Decreases		192,136	2,864,841		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I | Date/Time Prepared: 5/27/2022 5:01 pm

		Beginning Balances	Acquisitions Purchases	Donation	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	675,791	0	0	0	0	1.00
2.00	Land Improvements	484,426	0	0	0	0	2.00
3.00	Buildings and Fixtures	17,403,786	39,361	0	39,361	0	3.00
4.00	Building Improvements	1,808,886	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	12,722,058	623,698	0	623,698	1,419,452	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,094,947	663,059	0	663,059	1,419,452	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	33,094,947	663,059	0	663,059	1,419,452	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	675,791	0	1.00
2.00	Land Improvements	484,426	0	2.00
3.00	Buildings and Fixtures	17,443,147	0	3.00
4.00	Building Improvements	1,808,886	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	11,926,304	1,976,778	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,338,554	1,976,778	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	32,338,554	1,976,778	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II | Date/Time Prepared: 5/27/2022 5:01 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	1,226,926	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,226,926	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,226,926	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	1,226,926	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III Date/Time Prepared: 5/27/2022 5:01 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,235,365	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,235,365	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	594	39,431	0	307,962	1,583,352	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	594	39,431	0	307,962	1,583,352	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/27/2022 5:01 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-77,163	CENTRAL SERVICES & SUPPLY	14.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,010,002			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	937,973			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-49,198	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-176	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
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
19.02	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.02
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/27/2022 5:01 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	HAF OFFSET	A	-2,033,783	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OTHER REVENUE	B	-2,713	ADULTS & PEDIATRICS	30.00	0	34.00
34.01	OTHER REVENUE	B	-200,370	ADMINISTRATIVE & GENERAL	5.00	0	34.01
34.02	OTHER REVENUE	B	-3,428	CAFETERIA	11.00	0	34.02
34.04	OTHER REVENUE	B	-6,864	RURAL HEALTH CLINIC	88.00	0	34.04
34.05	OTHER REVENUE	B	-4,000	BROOK RHC	88.01	0	34.05
35.00	LOBBYING	A	-734	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	ANESTHESIA	A	-51,973	OPERATING ROOM	50.00	0	36.00
37.00	DEPRECIATION CARRY FORWARD	A	8,439	CAP REL COSTS-BLDG & FIXT	1.00	9	37.00
38.00	MARKETING / ADVERTISING	A	-749	ADMINISTRATIVE & GENERAL	5.00	0	38.00
38.01	MARKETING / ADVERTISING	A	2,317	RADIOLOGY-DIAGNOSTIC	54.00	0	38.01
38.02	MARKETING / ADVERTISING	A	-6,954	OPERATION OF PLANT	7.00	0	38.02
38.03	MARKETING / ADVERTISING	A	-28	CENTRAL SERVICES & SUPPLY	14.00	0	38.03
38.04	MARKETING / ADVERTISING	A	-8,000	RURAL HEALTH CLINIC	88.00	0	38.04
39.00	PHYSICIAN RHC SALARY	A	-46,619	RURAL HEALTH CLINIC	88.00	0	39.00
39.01	PHYSICIAN RHC SALARY	A	-49,362	BROOK RHC	88.01	0	39.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,603,387				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: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/27/2022 5:01 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOWABLE NEW CAPITAL COSTS	307,962	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	594	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLYEE BENEFITS	0	807,310	3.00
3.02	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	4,906,380	4,868,428	3.02
3.03	0.00			0	0	3.03
3.04	15.00	PHARMACY	COVP / PHARMACY	35,184	0	3.04
3.05	16.00	MEDICAL RECORDS & LIBRARY	HIM	458,524	0	3.05
3.06	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	799,713	799,713	3.06
3.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICES	94,378	0	3.07
3.09	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICES	562,218	0	3.09
4.00	13.00	NURSING ADMINISTRATION	SHARED SERVICES	228,899	0	4.00
4.01	15.00	PHARMACY	SHARED SERVICES	19,572	0	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,413,424	6,475,451	5.00

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

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

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

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

6.00	B	FRANCISCAN ALLI	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: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/27/2022 5:01 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	307,962	14	1.00
2.00	594	11	2.00
3.00	-807,310	0	3.00
3.02	37,952	0	3.02
3.03	0	0	3.03
3.04	35,184	0	3.04
3.05	458,524	0	3.05
3.06	0	11	3.06
3.07	94,378	0	3.07
3.09	562,218	0	3.09
4.00	228,899	0	4.00
4.01	19,572	0	4.01
5.00	937,973		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: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 5/27/2022 5:01 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	66,701	66,701	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	500,397	500,397	0	0	0	2.00
3.00	50.00	OPERATING ROOM	109,400	109,400	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	12,508	12,508	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	14,996	14,996	0	0	0	5.00
6.00	90.00	CLINIC	225,000	225,000	0	0	0	6.00
7.00	90.01	WOUND CARE	81,000	81,000	0	0	0	7.00
8.00	91.00	EMERGENCY	991,767	0	991,767	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			2,001,769	1,010,002	991,767		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.01	WOUND CARE	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	66,701		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	500,397		2.00
3.00	50.00	OPERATING ROOM	0	0	0	109,400		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	12,508		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	14,996		5.00
6.00	90.00	CLINIC	0	0	0	225,000		6.00
7.00	90.01	WOUND CARE	0	0	0	81,000		7.00
8.00	91.00	EMERGENCY	0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,010,002		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/27/2022 5:01 pm

Physical Therapy | Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	9	1.00
2.00	Line 1 multiplied by 15 hours per week	135	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	41	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	0.00	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	355.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	82.91	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.46	41.46	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	29,454	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	29,454	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	29,454	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	29,454	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	1,700	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	1,700	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	1,700	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/27/2022 5:01 pm

Physical Therapy — Cost

		1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	82.91	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	29,454	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	29,454	63.00
64.00	Total cost of outside supplier services (from your records)	0	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	1,700	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	1,700	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/27/2022 5:01 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,583,352	1,583,352				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,654,691	30,426	0	2,685,117		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,307,268	159,257	0	712,784	10,179,309	5.00
7.00	00700	OPERATION OF PLANT	1,381,182	180,819	0	59,439	1,621,440	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	82,016	19,321	0	5,151	106,488	8.00
9.00	00900	HOUSEKEEPING	450,118	21,684	0	66,810	538,612	9.00
10.00	01000	DIETARY	134,027	21,415	0	16,882	172,324	10.00
11.00	01100	CAFETERIA	188,909	28,455	0	30,424	247,788	11.00
13.00	01300	NURSING ADMINISTRATION	573,555	4,885	0	41,185	619,625	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	89,951	52,612	0	6,317	148,880	14.00
15.00	01500	PHARMACY	444,222	13,407	0	62,261	519,890	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	458,736	19,701	0	76	478,513	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,369,781	105,678	0	352,072	1,827,531	30.00
31.00	03100	INTENSIVE CARE UNIT	513,854	9,220	0	100,435	623,509	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,011,614	111,947	0	140,257	1,263,818	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,362,763	63,558	0	182,841	1,609,162	54.00
60.00	06000	LABORATORY	2,256,146	34,626	0	0	2,290,772	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,200	1,249	0	0	7,449	63.00
65.00	06500	RESPIRATORY THERAPY	714,585	46,172	0	131,898	892,655	65.00
66.00	06600	PHYSICAL THERAPY	524,059	26,031	0	96,725	646,815	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	474,571	115,571	0	86,288	676,430	66.01
67.00	06700	OCCUPATIONAL THERAPY	95,078	5,277	0	17,606	117,961	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	109,741	24,121	0	21,142	155,004	67.01
68.00	06800	SPEECH PATHOLOGY	94,720	4,469	0	18,354	117,543	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	110,174	15,648	0	21,149	146,971	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	632,299	0	0	0	632,299	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	193,163	0	0	0	193,163	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,677,219	0	0	0	2,677,219	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	335,749	0	0	54,416	390,165	88.00
88.01	08801	BROOK RHC	347,642	31,491	0	60,917	440,050	88.01
90.00	09000	CLINIC	908,386	158,265	0	158,990	1,225,641	90.00
90.01	09001	WOUND CARE	28,794	12,109	0	5,384	46,287	90.01
91.00	09100	EMERGENCY	2,133,795	95,833	0	222,142	2,451,770	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,248,360	1,413,247	0	2,671,945	33,065,083	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,042	3,367	0	0	5,409	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ALTERNACARE	36,581	0	0	7,075	43,656	194.00
194.01	07951	SPORTS MEDICINE	31,565	0	0	6,077	37,642	194.01
194.02	07952	UNUSED SPACE	0	166,738	0	0	166,738	194.02
194.03	07953	LAFAYETTE HHA BRANCH	2,556	0	0	20	2,576	194.03
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)	33,321,104	1,583,352	0	2,685,117	33,321,104	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/27/2022 5:01 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	10,179,309					5.00
7.00	00700	OPERATION OF PLANT	713,218	2,334,658				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,841	37,192	190,521			8.00
9.00	00900	HOUSEKEEPING	236,918	41,740	6,821	824,091		9.00
10.00	01000	DIETARY	75,800	41,222	0	15,060	304,406	10.00
11.00	01100	CAFETERIA	108,994	54,774	2,144	20,011	0	11.00
13.00	01300	NURSING ADMINISTRATION	272,553	9,404	0	3,436	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	65,487	101,275	0	36,999	0	14.00
15.00	01500	PHARMACY	228,682	25,808	0	9,428	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	210,482	37,922	0	13,854	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	803,871	203,423	38,796	74,317	292,731	30.00
31.00	03100	INTENSIVE CARE UNIT	274,261	17,747	0	6,484	11,675	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	555,912	215,490	8,980	78,726	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	707,817	122,346	27,693	44,697	0	54.00
60.00	06000	LABORATORY	1,007,635	66,653	0	24,350	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,277	2,404	0	878	0	63.00
65.00	06500	RESPIRATORY THERAPY	392,649	88,878	6,848	32,470	0	65.00
66.00	06600	PHYSICAL THERAPY	284,513	50,107	8,986	18,306	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	297,539	222,466	0	81,274	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	51,887	10,158	0	3,711	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	68,181	46,431	0	16,963	0	67.01
68.00	06800	SPEECH PATHOLOGY	51,703	8,603	0	3,143	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	64,648	30,121	0	11,004	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	278,127	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	84,966	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,177,617	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	171,621	0	21,200	0	0	88.00
88.01	08801	BROOK RHC	193,563	60,619	0	22,146	0	88.01
90.00	09000	CLINIC	539,119	304,651	11,998	111,299	0	90.00
90.01	09001	WOUND CARE	20,360	23,310	0	8,516	0	90.01
91.00	09100	EMERGENCY	1,078,453	184,473	57,055	67,394	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,066,694	2,007,217	190,521	704,466	304,406	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,379	6,481	0	2,368	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ALTERNACARE	19,203	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	16,557	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	73,343	320,960	0	117,257	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	1,133	0	0	0	0	194.03
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)	10,179,309	2,334,658	190,521	824,091	304,406	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/27/2022 5:01 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	433,711					11.00
13.00	01300	NURSING ADMINISTRATION	11,182	916,200				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,715	0	354,356			14.00
15.00	01500	PHARMACY	16,904	0	12,652	813,364		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	740,771	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	95,595	258,591	0	83	154,889	30.00
31.00	03100	INTENSIVE CARE UNIT	27,269	107,472	0	0	44,186	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,081	20,537	0	816	61,705	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,644	0	0	5,932	80,440	54.00
60.00	06000	LABORATORY	0	0	0	84	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	35,812	12,274	0	0	58,028	65.00
66.00	06600	PHYSICAL THERAPY	26,262	0	0	45	42,554	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	0	0	90	37,962	66.01
67.00	06700	OCCUPATIONAL THERAPY	4,780	0	0	0	7,746	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	0	0	0	9,301	67.01
68.00	06800	SPEECH PATHOLOGY	4,983	0	0	0	8,075	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	0	0	0	9,304	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	272,482	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	68,889	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	797,095	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,693	23,940	88.00
88.01	08801	BROOK RHC	16,540	414	0	4,760	26,800	88.01
90.00	09000	CLINIC	43,168	136,128	0	16	69,947	90.00
90.01	09001	WOUND CARE	1,462	4,667	0	615	2,369	90.01
91.00	09100	EMERGENCY	60,314	376,117	0	129	97,730	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	433,711	916,200	354,023	813,358	734,976	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	333	6	0	192.00
194.00	07950	ALTERNACARE	0	0	0	0	3,113	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	2,673	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	9	194.03
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)	433,711	916,200	354,356	813,364	740,771	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/27/2022 5:01 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	3,749,827	0	3,749,827	30.00
31.00	03100	INTENSIVE CARE UNIT	1,112,603	0	1,112,603	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,244,065	0	2,244,065	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,647,731	0	2,647,731	54.00
60.00	06000	LABORATORY	3,389,494	0	3,389,494	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	14,008	0	14,008	63.00
65.00	06500	RESPIRATORY THERAPY	1,519,614	0	1,519,614	65.00
66.00	06600	PHYSICAL THERAPY	1,077,588	0	1,077,588	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	1,315,761	0	1,315,761	66.01
67.00	06700	OCCUPATIONAL THERAPY	196,243	0	196,243	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	295,880	0	295,880	67.01
68.00	06800	SPEECH PATHOLOGY	194,050	0	194,050	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	262,048	0	262,048	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,182,908	0	1,182,908	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	347,018	0	347,018	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,651,931	0	4,651,931	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	610,619	0	610,619	88.00
88.01	08801	BROOK RHC	764,892	0	764,892	88.01
90.00	09000	CLINIC	2,441,967	0	2,441,967	90.00
90.01	09001	WOUND CARE	107,586	0	107,586	90.01
91.00	09100	EMERGENCY	4,373,435	0	4,373,435	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,499,268	0	32,499,268	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,637	0	16,637	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	339	0	339	192.00
194.00	07950	ALTERNACARE	65,972	0	65,972	194.00
194.01	07951	SPORTS MEDICINE	56,872	0	56,872	194.01
194.02	07952	UNUSED SPACE	678,298	0	678,298	194.02
194.03	07953	LAFAYETTE HHA BRANCH	3,718	0	3,718	194.03
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)	33,321,104	0	33,321,104	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1324

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

Worksheet B Part II
Date/Time Prepared: 5/27/2022 5:01 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	30,426	0	30,426	30,426	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	159,257	0	159,257	8,079	5.00
7.00	00700	OPERATION OF PLANT	0	180,819	0	180,819	673	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,321	0	19,321	58	8.00
9.00	00900	HOUSEKEEPING	0	21,684	0	21,684	757	9.00
10.00	01000	DIETARY	0	21,415	0	21,415	191	10.00
11.00	01100	CAFETERIA	0	28,455	0	28,455	345	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,885	0	4,885	467	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	52,612	0	52,612	72	14.00
15.00	01500	PHARMACY	0	13,407	0	13,407	705	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,701	0	19,701	1	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	105,678	0	105,678	3,989	30.00
31.00	03100	INTENSIVE CARE UNIT	0	9,220	0	9,220	1,138	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	111,947	0	111,947	1,589	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	63,558	0	63,558	2,072	54.00
60.00	06000	LABORATORY	0	34,626	0	34,626	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,249	0	1,249	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	46,172	0	46,172	1,494	65.00
66.00	06600	PHYSICAL THERAPY	0	26,031	0	26,031	1,096	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	115,571	0	115,571	978	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	5,277	0	5,277	199	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	24,121	0	24,121	240	67.01
68.00	06800	SPEECH PATHOLOGY	0	4,469	0	4,469	208	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	15,648	0	15,648	240	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	617	88.00
88.01	08801	BROOK RHC	0	31,491	0	31,491	690	88.01
90.00	09000	CLINIC	0	158,265	0	158,265	1,801	90.00
90.01	09001	WOUND CARE	0	12,109	0	12,109	61	90.01
91.00	09100	EMERGENCY	0	95,833	0	95,833	2,517	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,413,247	0	1,413,247	30,277	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,367	0	3,367	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ALTERNACARE	0	0	0	0	80	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	69	194.01
194.02	07952	UNUSED SPACE	0	166,738	0	166,738	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
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	1,583,352	0	1,583,352	30,426	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/27/2022 5:01 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	167,336					5.00
7.00	00700	OPERATION OF PLANT	11,725	193,217				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	770	3,078	23,227			8.00
9.00	00900	HOUSEKEEPING	3,895	3,454	832	30,622		9.00
10.00	01000	DIETARY	1,246	3,412	0	560	26,824	10.00
11.00	01100	CAFETERIA	1,792	4,533	261	744	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,481	778	0	128	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,077	8,382	0	1,375	0	14.00
15.00	01500	PHARMACY	3,759	2,136	0	350	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,460	3,138	0	515	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,215	16,835	4,730	2,762	25,795	30.00
31.00	03100	INTENSIVE CARE UNIT	4,509	1,469	0	241	1,029	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,139	17,834	1,095	2,925	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,636	10,125	3,376	1,661	0	54.00
60.00	06000	LABORATORY	16,565	5,516	0	905	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	54	199	0	33	0	63.00
65.00	06500	RESPIRATORY THERAPY	6,455	7,356	835	1,207	0	65.00
66.00	06600	PHYSICAL THERAPY	4,677	4,147	1,096	680	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	4,891	18,411	0	3,020	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	853	841	0	138	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	1,121	3,843	0	630	0	67.01
68.00	06800	SPEECH PATHOLOGY	850	712	0	117	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	1,063	2,493	0	409	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,572	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,397	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,352	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,821	0	2,585	0	0	88.00
88.01	08801	BROOK RHC	3,182	5,017	0	823	0	88.01
90.00	09000	CLINIC	8,863	25,213	1,463	4,136	0	90.00
90.01	09001	WOUND CARE	335	1,929	0	316	0	90.01
91.00	09100	EMERGENCY	17,729	15,267	6,954	2,504	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	165,484	166,118	23,227	26,179	26,824	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	39	536	0	88	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ALTERNACARE	316	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	272	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	1,206	26,563	0	4,355	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	19	0	0	0	0	194.03
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)	167,336	193,217	23,227	30,622	26,824	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/27/2022 5:01 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	36,130					11.00
13.00	01300	NURSING ADMINISTRATION	932	11,671				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	143	0	63,661			14.00
15.00	01500	PHARMACY	1,408	0	2,273	24,038		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	26,815	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,963	3,294	0	2	5,607	30.00
31.00	03100	INTENSIVE CARE UNIT	2,272	1,369	0	0	1,599	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,172	262	0	24	2,234	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,136	0	0	175	2,912	54.00
60.00	06000	LABORATORY	0	0	0	2	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,983	156	0	0	2,100	65.00
66.00	06600	PHYSICAL THERAPY	2,188	0	0	1	1,540	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	0	0	3	1,374	66.01
67.00	06700	OCCUPATIONAL THERAPY	398	0	0	0	280	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	0	0	0	337	67.01
68.00	06800	SPEECH PATHOLOGY	415	0	0	0	292	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	0	0	0	337	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	48,952	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	12,376	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	23,559	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	109	867	88.00
88.01	08801	BROOK RHC	1,378	5	0	141	970	88.01
90.00	09000	CLINIC	3,596	1,734	0	0	2,532	90.00
90.01	09001	WOUND CARE	122	59	0	18	86	90.01
91.00	09100	EMERGENCY	5,024	4,792	0	4	3,538	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,130	11,671	63,601	24,038	26,605	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	60	0	0	192.00
194.00	07950	ALTERNACARE	0	0	0	0	113	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	97	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
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)	36,130	11,671	63,661	24,038	26,815	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/27/2022 5:01 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	189,870	0	189,870	30.00
31.00	03100	INTENSIVE CARE UNIT	22,846	0	22,846	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	150,221	0	150,221	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,651	0	99,651	54.00
60.00	06000	LABORATORY	57,614	0	57,614	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,535	0	1,535	63.00
65.00	06500	RESPIRATORY THERAPY	68,758	0	68,758	65.00
66.00	06600	PHYSICAL THERAPY	41,456	0	41,456	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	144,248	0	144,248	66.01
67.00	06700	OCCUPATIONAL THERAPY	7,986	0	7,986	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	30,292	0	30,292	67.01
68.00	06800	SPEECH PATHOLOGY	7,063	0	7,063	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	20,190	0	20,190	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	53,524	0	53,524	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,773	0	13,773	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,911	0	42,911	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	6,999	0	6,999	88.00
88.01	08801	BROOK RHC	43,697	0	43,697	88.01
90.00	09000	CLINIC	207,603	0	207,603	90.00
90.01	09001	WOUND CARE	15,035	0	15,035	90.01
91.00	09100	EMERGENCY	154,162	0	154,162	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,379,434	0	1,379,434	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,030	0	4,030	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	60	0	60	192.00
194.00	07950	ALTERNACARE	509	0	509	194.00
194.01	07951	SPORTS MEDICINE	438	0	438	194.01
194.02	07952	UNUSED SPACE	198,862	0	198,862	194.02
194.03	07953	LAFAYETTE HHA BRANCH	19	0	19	194.03
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)	1,583,352	0	1,583,352	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 5:01 pm

		Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	129,317					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		129,317				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,485	2,485	13,709,457			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,007	13,007	3,639,291	-10,179,309	23,141,795	5.00
7.00	00700	OPERATION OF PLANT	14,768	14,768	303,478	0	1,621,440	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,578	1,578	26,297	0	106,488	8.00
9.00	00900	HOUSEKEEPING	1,771	1,771	341,115	0	538,612	9.00
10.00	01000	DIETARY	1,749	1,749	86,194	0	172,324	10.00
11.00	01100	CAFETERIA	2,324	2,324	155,334	0	247,788	11.00
13.00	01300	NURSING ADMINISTRATION	399	399	210,279	0	619,625	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,297	4,297	32,254	0	148,880	14.00
15.00	01500	PHARMACY	1,095	1,095	317,885	0	519,890	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,609	1,609	388	0	478,513	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,631	8,631	1,797,581	0	1,827,531	30.00
31.00	03100	INTENSIVE CARE UNIT	753	753	512,792	0	623,509	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,143	9,143	716,110	0	1,263,818	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,191	5,191	933,536	0	1,609,162	54.00
60.00	06000	LABORATORY	2,828	2,828	0	0	2,290,772	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	102	102	0	0	7,449	63.00
65.00	06500	RESPIRATORY THERAPY	3,771	3,771	673,435	0	892,655	65.00
66.00	06600	PHYSICAL THERAPY	2,126	2,126	493,852	0	646,815	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	9,439	9,439	440,562	0	676,430	66.01
67.00	06700	OCCUPATIONAL THERAPY	431	431	89,892	0	117,961	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	1,970	1,970	107,946	0	155,004	67.01
68.00	06800	SPEECH PATHOLOGY	365	365	93,708	0	117,543	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	1,278	1,278	107,979	0	146,971	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	632,299	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	193,163	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,677,219	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	277,833	0	390,165	88.00
88.01	08801	BROOK RHC	2,572	2,572	311,027	0	440,050	88.01
90.00	09000	CLINIC	12,926	12,926	811,757	0	1,225,641	90.00
90.01	09001	WOUND CARE	989	989	27,491	0	46,287	90.01
91.00	09100	EMERGENCY	7,827	7,827	1,134,192	0	2,451,770	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,424	115,424	13,642,208	-10,179,309	22,885,774	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	275	275	0	0	5,409	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ALTERNACARE	0	0	36,124	0	43,656	194.00
194.01	07951	SPORTS MEDICINE	0	0	31,025	0	37,642	194.01
194.02	07952	UNUSED SPACE	13,618	13,618	0	0	166,738	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	100	0	2,576	194.03
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)	1,583,352	0	2,685,117		10,179,309	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.243959	0.000000	0.195859		0.439867	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			30,426		167,336	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002219		0.007231	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 5:01 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	
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: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 5:01 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (SALARIES)	
			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	99,057					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,578	61,676				8.00
9.00	00900	HOUSEKEEPING	1,771	2,208	95,708			9.00
10.00	01000	DIETARY	1,749	0	1,749	13,767		10.00
11.00	01100	CAFETERIA	2,324	694	2,324	0	8,155,791	11.00
13.00	01300	NURSING ADMINISTRATION	399	0	399	0	210,279	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,297	0	4,297	0	32,254	14.00
15.00	01500	PHARMACY	1,095	0	1,095	0	317,885	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,609	0	1,609	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,631	12,559	8,631	13,239	1,797,581	30.00
31.00	03100	INTENSIVE CARE UNIT	753	0	753	528	512,792	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,143	2,907	9,143	0	716,110	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,191	8,965	5,191	0	933,536	54.00
60.00	06000	LABORATORY	2,828	0	2,828	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	102	0	102	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,771	2,217	3,771	0	673,435	65.00
66.00	06600	PHYSICAL THERAPY	2,126	2,909	2,126	0	493,852	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	9,439	0	9,439	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	431	0	431	0	89,892	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	1,970	0	1,970	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	365	0	365	0	93,708	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	1,278	0	1,278	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,863	0	0	0	88.00
88.01	08801	BROOK RHC	2,572	0	2,572	0	311,027	88.01
90.00	09000	CLINIC	12,926	3,884	12,926	0	811,757	90.00
90.01	09001	WOUND CARE	989	0	989	0	27,491	90.01
91.00	09100	EMERGENCY	7,827	18,470	7,827	0	1,134,192	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,164	61,676	81,815	13,767	8,155,791	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	275	0	275	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ALTERNACARE	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	13,618	0	13,618	0	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,334,658	190,521	824,091	304,406	433,711	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.568834	3.089062	8.610471	22.111281	0.053178	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	193,217	23,227	30,622	26,824	36,130	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.950564	0.376597	0.319952	1.948427	0.004430	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: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 5:01 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS SALARIES)		
			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	139,589					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	993,608				14.00
15.00	01500	PHARMACY	0	35,477	2,739,228			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	8,596,942		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,398	0	280	1,797,581		30.00
31.00	03100	INTENSIVE CARE UNIT	16,374	0	0	512,792		31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0		32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,129	0	2,747	716,110		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	19,979	933,536		54.00
60.00	06000	LABORATORY	0	0	284	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	1,870	0	0	673,435		65.00
66.00	06600	PHYSICAL THERAPY	0	0	150	493,852		66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	0	303	440,562		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	89,892		67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	0	0	107,946		67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	93,708		68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	0	0	107,979		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	764,035	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	193,163	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,684,438	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	12,438	277,833		88.00
88.01	08801	BROOK RHC	63	0	16,030	311,027		88.01
90.00	09000	CLINIC	20,740	0	55	811,757		90.00
90.01	09001	WOUND CARE	711	0	2,071	27,491		90.01
91.00	09100	EMERGENCY	57,304	0	434	1,134,192		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0		115.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	139,589	992,675	2,739,209	8,529,693		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	933	19	0		192.00
194.00	07950	ALTERNACARE	0	0	0	36,124		194.00
194.01	07951	SPORTS MEDICINE	0	0	0	31,025		194.01
194.02	07952	UNUSED SPACE	0	0	0	0		194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	100		194.03
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)	916,200	354,356	813,364	740,771		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.563554	0.356636	0.296932	0.086167		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	11,671	63,661	24,038	26,815		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.083610	0.064071	0.008775	0.003119		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-1324	Period: From 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Prepared: 5/27/2022 5:01 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS SALARIES)		
			13.00	14.00	15.00	16.00		
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 5:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,749,827		3,749,827	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,112,603		1,112,603	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0		0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,244,065		2,244,065	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,647,731		2,647,731	0	0	54.00
60.00	06000	LABORATORY	3,389,494		3,389,494	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	14,008		14,008	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,519,614	0	1,519,614	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,077,588	0	1,077,588	0	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	1,315,761	0	1,315,761	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	196,243	0	196,243	0	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	295,880	0	295,880	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	194,050	0	194,050	0	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	262,048	0	262,048	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,182,908		1,182,908	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	347,018		347,018	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,651,931		4,651,931	0	0	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	610,619		610,619	0	0	88.00
88.01	08801	BROOK RHC	764,892		764,892	0	0	88.01
90.00	09000	CLINIC	2,441,967		2,441,967	0	0	90.00
90.01	09001	WOUND CARE	107,586		107,586	0	0	90.01
91.00	09100	EMERGENCY	4,373,435		4,373,435	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	950,596		950,596		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	33,449,864	0	33,449,864	0	0	200.00
201.00		Less Observation Beds	950,596		950,596		0	201.00
202.00		Total (see instructions)	32,499,268	0	32,499,268	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/27/2022 5:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,471,882		3,471,882			30.00
31.00	03100	INTENSIVE CARE UNIT	160,986		160,986			31.00
32.00	03200	CORONARY CARE UNIT	0		0			32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	138,184	2,758,851	2,897,035	0.774607	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	569,408	13,438,857	14,008,265	0.189012	0.000000	54.00
60.00	06000	LABORATORY	1,316,185	11,991,398	13,307,583	0.254704	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	20,606	6,828	27,434	0.510607	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	420,204	2,483,047	2,903,251	0.523418	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	133,564	1,516,637	1,650,201	0.653004	0.000000	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	229,728	2,319,375	2,549,103	0.516166	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	227,697	245,190	472,887	0.414989	0.000000	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	263,942	263,942	1.121004	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	16,593	210,851	227,444	0.853177	0.000000	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	88	461,631	461,719	0.567549	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	522,043	5,484,226	6,006,269	0.196946	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	268,262	1,566,690	1,834,952	0.189116	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,570,632	24,481,644	26,052,276	0.178561	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	176,925	176,925			88.00
88.01	08801	BROOK RHC	0	244,221	244,221			88.01
90.00	09000	CLINIC	136,482	4,295,398	4,431,880	0.551000	0.000000	90.00
90.01	09001	WOUND CARE	2,264	305,450	307,714	0.349630	0.000000	90.01
91.00	09100	EMERGENCY	332,358	7,627,612	7,959,970	0.549429	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	91,202	936,962	1,028,164	0.924557	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	9,628,368	80,815,735	90,444,103			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,628,368	80,815,735	90,444,103			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/27/2022 5:01 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
32.00	03200	CORONARY CARE UNIT		32.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	BROOK RHC		88.01
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CARE	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	98.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)		115.00
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: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 5:01 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,749,827		3,749,827	0	3,749,827	30.00
31.00	03100	INTENSIVE CARE UNIT	1,112,603		1,112,603	0	1,112,603	31.00
32.00	03200	CORONARY CARE UNIT	0		0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,244,065		2,244,065	0	2,244,065	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,647,731		2,647,731	0	2,647,731	54.00
60.00	06000	LABORATORY	3,389,494		3,389,494	0	3,389,494	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	14,008		14,008	0	14,008	63.00
65.00	06500	RESPIRATORY THERAPY	1,519,614	0	1,519,614	0	1,519,614	65.00
66.00	06600	PHYSICAL THERAPY	1,077,588	0	1,077,588	0	1,077,588	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	1,315,761	0	1,315,761	0	1,315,761	66.01
67.00	06700	OCCUPATIONAL THERAPY	196,243	0	196,243	0	196,243	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	295,880	0	295,880	0	295,880	67.01
68.00	06800	SPEECH PATHOLOGY	194,050	0	194,050	0	194,050	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	262,048	0	262,048	0	262,048	68.01
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,182,908		1,182,908	0	1,182,908	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	347,018		347,018	0	347,018	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,651,931		4,651,931	0	4,651,931	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	610,619		610,619	0	610,619	88.00
88.01	08801	BROOK RHC	764,892		764,892	0	764,892	88.01
90.00	09000	CLINIC	2,441,967		2,441,967	0	2,441,967	90.00
90.01	09001	WOUND CARE	107,586		107,586	0	107,586	90.01
91.00	09100	EMERGENCY	4,373,435		4,373,435	0	4,373,435	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	950,596		950,596		950,596	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	33,449,864	0	33,449,864	0	33,449,864	200.00
201.00		Less Observation Beds	950,596		950,596		950,596	201.00
202.00		Total (see instructions)	32,499,268	0	32,499,268	0	32,499,268	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/27/2022 5:01 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,471,882		3,471,882			30.00
31.00	03100	INTENSIVE CARE UNIT	160,986		160,986			31.00
32.00	03200	CORONARY CARE UNIT	0		0			32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	138,184	2,758,851	2,897,035	0.774607	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	569,408	13,438,857	14,008,265	0.189012	0.000000	54.00
60.00	06000	LABORATORY	1,316,185	11,991,398	13,307,583	0.254704	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	20,606	6,828	27,434	0.510607	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	420,204	2,483,047	2,903,251	0.523418	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	133,564	1,516,637	1,650,201	0.653004	0.000000	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	229,728	2,319,375	2,549,103	0.516166	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	227,697	245,190	472,887	0.414989	0.000000	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	263,942	263,942	1.121004	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	16,593	210,851	227,444	0.853177	0.000000	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	88	461,631	461,719	0.567549	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	522,043	5,484,226	6,006,269	0.196946	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	268,262	1,566,690	1,834,952	0.189116	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,570,632	24,481,644	26,052,276	0.178561	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	176,925	176,925	3.451287	0.000000	88.00
88.01	08801	BROOK RHC	0	244,221	244,221	3.131967	0.000000	88.01
90.00	09000	CLINIC	136,482	4,295,398	4,431,880	0.551000	0.000000	90.00
90.01	09001	WOUND CARE	2,264	305,450	307,714	0.349630	0.000000	90.01
91.00	09100	EMERGENCY	332,358	7,627,612	7,959,970	0.549429	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	91,202	936,962	1,028,164	0.924557	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	9,628,368	80,815,735	90,444,103			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,628,368	80,815,735	90,444,103			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/27/2022 5:01 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
32.00	03200	CORONARY CARE UNIT		32.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08801	BROOK RHC	0.000000	88.01
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CARE	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	98.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)		115.00
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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/27/2022 5:01 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	150,221	2,897,035	0.051853	52,886	2,742	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,651	14,008,265	0.007114	158,721	1,129	54.00
60.00	06000	LABORATORY	57,614	13,307,583	0.004329	527,316	2,283	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,535	27,434	0.055952	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	68,758	2,903,251	0.023683	139,917	3,314	65.00
66.00	06600	PHYSICAL THERAPY	41,456	1,650,201	0.025122	37,536	943	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	144,248	2,549,103	0.056588	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	7,986	472,887	0.016888	36,313	613	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	30,292	263,942	0.114768	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	7,063	227,444	0.031054	6,036	187	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	20,190	461,719	0.043728	88	4	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	53,524	6,006,269	0.008911	106,536	949	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,773	1,834,952	0.007506	105,041	788	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,911	26,052,276	0.001647	440,092	725	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,999	176,925	0.039559	0	0	88.00
88.01	08801	BROOK RHC	43,697	244,221	0.178924	0	0	88.01
90.00	09000	CLINIC	207,603	4,431,880	0.046843	5,537	259	90.00
90.01	09001	WOUND CARE	15,035	307,714	0.048860	0	0	90.01
91.00	09100	EMERGENCY	154,162	7,959,970	0.019367	76,565	1,483	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	48,132	1,028,164	0.046814	2,689	126	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50 through 199)	1,214,850	86,811,235		1,695,273	15,545	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1324

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

Worksheet D Part IV

Date/Time Prepared: 5/27/2022 5:01 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	BROOK RHC	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/27/2022 5:01 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	2,897,035	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,008,265	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	13,307,583	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	27,434	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,903,251	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,650,201	0.000000	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	0	0	2,549,103	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	472,887	0.000000	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	0	0	263,942	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	227,444	0.000000	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	0	0	461,719	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,006,269	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,834,952	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,052,276	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	176,925	0.000000	88.00
88.01	08801	BROOK RHC	0	0	0	244,221	0.000000	88.01
90.00	09000	CLINIC	0	0	0	4,431,880	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	307,714	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	7,959,970	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,028,164	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	0	86,811,235		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/27/2022 5:01 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	52,886	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	158,721	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	527,316	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	139,917	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	37,536	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	36,313	0	0	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0.000000	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	6,036	0	0	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.000000	88	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	106,536	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	105,041	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	440,092	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	BROOK RHC	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	5,537	0	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	76,565	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,689	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Total (lines 50 through 199)		1,695,273	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V | Date/Time Prepared: 5/27/2022 5:01 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	0.774607	0	743,922	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.189012	0	4,176,260	0	0	54.00
60.00	06000	LABORATORY	0.254704	0	1,669,719	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.510607	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.523418	0	839,107	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.653004	0	816,630	0	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.516166	0	556,211	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.414989	0	55,487	0	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	1.121004	0	30,778	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.853177	0	32,947	0	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.567549	0	9,998	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.196946	0	1,265,607	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.189116	0	634,017	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.178561	0	14,961,723	399	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	BROOK RHC						88.01
90.00	09000	CLINIC	0.551000	0	1,298,388	15,655	0	90.00
90.01	09001	WOUND CARE	0.349630	0	92,729	0	0	90.01
91.00	09100	EMERGENCY	0.549429	0	1,335,158	49,462	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.924557	0	500,966	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	29,019,647	65,516	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	29,019,647	65,516	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V | Date/Time Prepared: 5/27/2022 5:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	576,247	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	789,363	0	54.00
60.00	06000	LABORATORY	425,284	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	439,204	0	65.00
66.00	06600	PHYSICAL THERAPY	533,263	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	287,097	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	23,026	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	34,502	0	67.01
68.00	06800	SPEECH PATHOLOGY	28,110	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	5,674	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	249,256	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	119,903	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,671,580	71	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	BROOK RHC			88.01
90.00	09000	CLINIC	715,412	8,626	90.00
90.01	09001	WOUND CARE	32,421	0	90.01
91.00	09100	EMERGENCY	733,575	27,176	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	463,172	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00		Subtotal (see instructions)	8,127,089	35,873	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	8,127,089	35,873	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 5:01 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,700	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,829	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,228	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	506	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	365	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	626	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)	506	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	155.02	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,749,827	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)	56,582	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	856,917	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,892,910	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)	2,892,910	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)	1,581.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	990,138	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)	990,138	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 5:01 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,112,603	49	22,706.18	12	272,474	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	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)	490,324	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,752,936	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)	800,335	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)	800,335	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)	601	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,581.69	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	950,596	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 5:01 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	189,870	3,749,827	0.050634	950,596	48,132	90.00
91.00	Nursing Program cost	0	3,749,827	0.000000	950,596	0	91.00
92.00	Allied health cost	0	3,749,827	0.000000	950,596	0	92.00
93.00	All other Medical Education	0	3,749,827	0.000000	950,596	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 5:01 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,700	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,829	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,228	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	506	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	365	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	31	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,749,827	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	812,596	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,937,231	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)	2,937,231	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)	1,605.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	49,784	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)	49,784	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 5:01 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,112,603	49	22,706.18	4	90,825	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	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)	327,318	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	467,927	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	601	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,605.92	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	965,158	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1324

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

Worksheet D-1

Date/Time Prepared: 5/27/2022 5:01 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	189,870	3,749,827	0.050634	965,158	48,870	90.00
91.00	Nursing Program cost	0	3,749,827	0.000000	965,158	0	91.00
92.00	Allied health cost	0	3,749,827	0.000000	965,158	0	92.00
93.00	All other Medical Education	0	3,749,827	0.000000	965,158	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/27/2022 5:01 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		890,608		30.00
31.00	03100	INTENSIVE CARE UNIT		27,132		31.00
32.00	03200	CORONARY CARE UNIT		0		32.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.774607	52,886	40,966	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.189012	158,721	30,000	54.00
60.00	06000	LABORATORY	0.254704	527,316	134,309	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.510607	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.523418	139,917	73,235	65.00
66.00	06600	PHYSICAL THERAPY	0.653004	37,536	24,511	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.516166	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.414989	36,313	15,069	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	1.121004	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.853177	6,036	5,150	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.567549	88	50	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.196946	106,536	20,982	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.189116	105,041	19,865	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.178561	440,092	78,583	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	BROOK RHC	0.000000		0	88.01
90.00	09000	CLINIC	0.551000	5,537	3,051	90.00
90.01	09001	WOUND CARE	0.349630	0	0	90.01
91.00	09100	EMERGENCY	0.549429	76,565	42,067	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.924557	2,689	2,486	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,695,273	490,324	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)		1,695,273		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1324 Component CCN: 15-Z324	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/27/2022 5:01 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
32.00	03200	CORONARY CARE UNIT				32.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.774607	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.189012	17,481	3,304	54.00
60.00	06000	LABORATORY	0.254704	47,207	12,024	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.510607	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.523418	51,092	26,742	65.00
66.00	06600	PHYSICAL THERAPY	0.653004	96,028	62,707	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.516166	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.414989	98,033	40,683	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	1.121004	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.853177	546	466	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.567549	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.196946	35,528	6,997	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.189116	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.178561	128,893	23,015	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	BROOK RHC	0.000000		0	88.01
90.00	09000	CLINIC	0.551000	0	0	90.00
90.01	09001	WOUND CARE	0.349630	2,264	792	90.01
91.00	09100	EMERGENCY	0.549429	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.924557	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		477,072	176,730	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)		477,072		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/27/2022 5:01 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		162,745		30.00
31.00	03100	INTENSIVE CARE UNIT		38,946		31.00
32.00	03200	CORONARY CARE UNIT		0		32.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.774607	37,579	29,109	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.189012	132,297	25,006	54.00
60.00	06000	LABORATORY	0.254704	172,797	44,012	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.510607	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.523418	35,909	18,795	65.00
66.00	06600	PHYSICAL THERAPY	0.653004	0	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.516166	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.414989	625	259	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	1.121004	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.853177	0	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.567549	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.196946	66,258	13,049	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.189116	77,270	14,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.178561	133,050	23,758	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	3.451287	0	0	88.00
88.01	08801	BROOK RHC	3.131967	0	0	88.01
90.00	09000	CLINIC	0.551000	130,945	72,151	90.00
90.01	09001	WOUND CARE	0.349630	0	0	90.01
91.00	09100	EMERGENCY	0.549429	89,173	48,994	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.924557	40,638	37,572	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		916,541	327,318	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)		916,541		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1324	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/27/2022 5:01 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,162,962	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)	8,162,962	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)	8,244,592	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)	62,884	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,410,458	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)	2,771,250	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)	2,771,250	30.00
31.00	Primary payer payments	15,721	31.00
32.00	Subtotal (line 30 minus line 31)	2,755,529	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)	730,480	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	474,812	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	500,587	36.00
37.00	Subtotal (see instructions)	3,230,341	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)	3,230,341	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	5,528,781	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)	-2,298,440	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: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I Date/Time Prepared: 5/27/2022 5:01 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,589,430		5,528,781	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,589,430		5,528,781	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		59,514		2,298,440	6.02
7.00	Total Medicare program liability (see instructions)		1,529,916		3,230,341	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: 15-1324 | Component CCN: 15-Z324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2022 5:01 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		884,541		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		884,541		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		90,978		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		975,519		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: 15-1324	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/27/2022 5:01 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1324 | Component CCN: 15-Z324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-2 | Date/Time Prepared: 5/27/2022 5:01 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)	808,338	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)	178,497	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	506	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)	986,835	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	986,835	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)	986,835	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	11,316	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	975,519	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)	975,519	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	884,541	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)	90,978	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: 15-1324	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prepared: 5/27/2022 5:01 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,752,936	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)	1,752,936	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,770,465	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)	1,770,465	19.00
20.00	Deductibles (exclude professional component)	259,548	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,510,917	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,510,917	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	29,229	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	18,999	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	6,765	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,529,916	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,529,916	30.00
30.01	Sequestration adjustment (see instructions)	0	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,589,430	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-59,514	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: 15-1324	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2022 5:01 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	467,927		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)	467,927	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)	467,927	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	916,541	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)	916,541	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)	916,541	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	448,614	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)	467,927	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	467,927	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)	467,927	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	467,927	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	467,927	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)	467,927	0	40.00
41.00	Interim payments	467,968	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-41	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: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/27/2022 5:01 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	-15,029,537	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	4,431,577	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	770,320	0	0	0	7.00
8.00	Prepaid expenses	89,252	0	0	0	8.00
9.00	Other current assets	644,488	0	0	0	9.00
10.00	Due from other funds	83,413	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	-9,010,487	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	675,791	0	0	0	12.00
13.00	Land improvements	509,926	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	19,176,030	0	0	0	15.00
16.00	Accumulated depreciation	-15,622,336	0	0	0	16.00
17.00	Leasehold improvements	613,142	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	12,094,550	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	17,447,103	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	239,914	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	239,914	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	8,676,530	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,401,688	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,133,462	0	0	0	38.00
39.00	Payroll taxes payable	58,861	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,290,558	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,884,569	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	23,336,895	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	23,336,895	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	32,221,464	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-23,544,934				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)	-23,544,934	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	8,676,530	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 Date/Time Prepared: 5/27/2022 5:01 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		-22,357,030		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,271,318				2.00
3.00	Total (sum of line 1 and line 2)		-23,628,348		0		3.00
4.00	TEMPORARY RESTRICTED NET ASSETS	83,413		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)		83,413		0		10.00
11.00	Subtotal (line 3 plus line 10)		-23,544,935		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)		-23,544,935		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	TEMPORARY RESTRICTED NET ASSETS		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: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/27/2022 5:01 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,692,905		2,692,905	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,692,905		2,692,905	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	118,618		118,618	11.00
12.00	CORONARY CARE UNIT	0		0	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)	118,618		118,618	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,811,523		2,811,523	17.00
18.00	Ancillary services	5,299,542	67,510,994	72,810,536	18.00
19.00	Outpatient services	349,270	14,543,945	14,893,215	19.00
20.00	RURAL HEALTH CLINIC	0	176,925	176,925	20.00
20.01	BROOK RHC	0	244,221	244,221	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE	0	0	0	26.00
27.00	NON-REIMBURSABLE	0	984,326	984,326	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,460,335	83,460,411	91,920,746	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		35,924,491		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)		35,924,491		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-3 | Date/Time Prepared: 5/27/2022 5:01 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	91,920,746	1.00
2.00	Less contractual allowances and discounts on patients' accounts	58,218,027	2.00
3.00	Net patient revenues (line 1 minus line 2)	33,702,719	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	35,924,491	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,221,772	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	95,299	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	49,287	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	176	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	1,035	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	2,962	20.00
21.00	Rental of vending machines	3,339	21.00
22.00	Rental of hospital space	6,864	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	14,475	24.00
24.50	COVID-19 PHE Funding	773,017	24.50
25.00	Total other income (sum of lines 6-24)	946,454	25.00
26.00	Total (line 5 plus line 25)	-1,275,318	26.00
27.00	TOTAL NON OPERATING REVENUE	-4,000	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-4,000	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,271,318	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1

Component CCN: 15-3990 | Date/Time Prepared: 5/27/2022 5:01 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	70,677	0	70,677	0	70,677	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	113,462	0	113,462	0	113,462	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	19,381	0	19,381	0	19,381	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	74,312	75,056	149,368	0	149,368	9.00
10.00	Subtotal (sum of lines 1 through 9)	277,832	75,056	352,888	0	352,888	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	4,782	4,782	0	4,782	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	52,000	52,000	-12,438	39,562	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	56,782	56,782	-12,438	44,344	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	277,832	131,838	409,670	-12,438	397,232	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	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	277,832	131,838	409,670	-12,438	397,232	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/27/2022 5:01 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	-46,619	24,058	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	113,462	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	19,381	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	149,368	9.00
10.00	Subtotal (sum of lines 1 through 9)	-46,619	306,269	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	4,782	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	-14,864	24,698	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	-14,864	29,480	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-61,483	335,749	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-61,483	335,749	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1

Component CCN: 15-8502 | Date/Time Prepared: 5/27/2022 5:01 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	72,510	0	72,510	0	72,510	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	107,119	0	107,119	0	107,119	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	49,962	0	49,962	0	49,962	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	81,434	78,598	160,032	0	160,032	9.00
10.00	Subtotal (sum of lines 1 through 9)	311,025	78,598	389,623	0	389,623	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	4,043	4,043	0	4,043	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	23,368	23,368	-16,030	7,338	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	27,411	27,411	-16,030	11,381	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	311,025	106,009	417,034	-16,030	401,004	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	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	311,025	106,009	417,034	-16,030	401,004	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1

Component CCN: 15-8502 | Date/Time Prepared: 5/27/2022 5:01 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	-49,362	23,148	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	107,119	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	49,962	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	160,032	9.00
10.00	Subtotal (sum of lines 1 through 9)	-49,362	340,261	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	4,043	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	-4,000	3,338	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	-4,000	7,381	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-53,362	347,642	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-53,362	347,642	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1324 Component CCN: 15-3990	Period: From 01/01/2021 To 12/31/2021	Worksheet M-2 Date/Time Prepared: 5/27/2022 5:01 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	0.08	38	4,200	336		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.00	1,306	2,100	2,100		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.08	1,344		2,436	2,436	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.08	1,344			2,436	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)	335,749	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)	335,749	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)	0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	274,870	15.00
16.00	Total overhead (sum of lines 14 and 15)	274,870	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	274,870	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	274,870	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	610,619	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-2 | Date/Time Prepared: 5/27/2022 5:01 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	0.08	80	4,200	336		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.00	1,753	2,100	2,100		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.08	1,833		2,436	2,436	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.08	1,833			2,436	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)	347,642	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)	347,642	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)	0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	417,250	15.00
16.00	Total overhead (sum of lines 14 and 15)	417,250	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	417,250	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	417,250	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	764,892	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1324 Component CCN: 15-3990	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/27/2022 5:01 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)		610,619	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		22,889	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		587,730	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		2,436	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)		2,436	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		241.27	7.00
		Calculation of Limit (1)		
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	87.52	100.00	8.00
9.00	Rate for Program covered visits (see instructions)	241.27	100.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	35	106	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	8,444	10,600	11.00
12.00	Program covered visits for mental health services (from contractor records)	11	35	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	2,654	3,500	13.00
14.00	Limit adjustment for mental health services (see instructions)	2,654	3,500	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	25,198	16.00
16.01	Total program charges (see instructions)(from contractor's records)		15,251	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		8,211	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		13,566	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.)		6,039	16.04
16.05	Total program cost (see instructions)	0	19,605	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,083	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		2,234	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		19,605	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		9,485	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		29,090	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)		29,090	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		32,484	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)		-3,394	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: 15-1324 Component CCN: 15-8502	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/27/2022 5:01 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)		764,892	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		30,706	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		734,186	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		2,436	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)		2,436	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		301.39	7.00
		Calculation of Limit (1)		
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	87.52	100.00	8.00
9.00	Rate for Program covered visits (see instructions)	301.39	100.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	102	307	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	30,742	30,700	11.00
12.00	Program covered visits for mental health services (from contractor records)	10	31	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	3,014	3,100	13.00
14.00	Limit adjustment for mental health services (see instructions)	3,014	3,100	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	67,556	16.00
16.01	Total program charges (see instructions)(from contractor's records)		44,475	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,456	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		9,806	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.)		38,498	16.04
16.05	Total program cost (see instructions)	0	48,304	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		9,628	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		6,969	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		48,304	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		8,546	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		56,850	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)		56,850	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		97,794	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)		-40,944	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: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/27/2022 5:01 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)	306,269	306,269	306,269	306,269	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.003089	0.006883	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	946	2,108	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	6,790	2,742	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	7,736	4,850	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	335,749	335,749	335,749	335,749	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	274,870	274,870	274,870	274,870	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.023041	0.014445	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	6,333	3,970	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	14,069	8,820	0	0	10.00
11.00	Total number of injections/infusions (from your records)	70	156	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	200.99	56.54	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	32	54	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)	6,432	3,053	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)		22,889			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)		9,485			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CCN: 15-1324 Component CCN: 15-8502	Period: From 01/01/2021 To 12/31/2021	Worksheet M-4 Date/Time Prepared: 5/27/2022 5:01 pm
	Title XVIII	RHC II	Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	340,261	340,261	340,261	340,261	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001596	0.007089	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	543	2,412	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	3,298	7,703	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	3,841	10,115	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	347,642	347,642	347,642	347,642	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	417,250	417,250	417,250	417,250	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.011049	0.029096	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	4,610	12,140	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	8,451	22,255	0	0	10.00
11.00	Total number of injections/infusions (from your records)	34	151	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	248.56	147.38	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	16	31	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)	3,977	4,569	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)		30,706			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		8,546			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1324 Component CCN: 15-3990	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/27/2022 5:01 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		32,484	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)		32,484	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		0	6.01
6.02	SETTLEMENT TO PROGRAM		3,394	6.02
7.00	Total Medicare program liability (see instructions)		29,090	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: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-5 | Date/Time Prepared: 5/27/2022 5:01 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		97,794	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)		97,794	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		0	6.01
6.02	SETTLEMENT TO PROGRAM		40,944	6.02
7.00	Total Medicare program liability (see instructions)		56,850	7.00

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