

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: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/29/2021 11:53 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/29/2021 Time: 11:53 am
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.	

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HAMILTON CENTER, INC. (15-4009) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) TRACIE SESSION
Officer or Administrator of Provider(s)

INTERIM CFO
Title

(Dated when report is electronically signed.)
Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	0	0	0	11,792	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing Bed - SNF	0	0	0	0	0	5.00
6.00 Swing Bed - NF	0	0	0	0	0	6.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	0	0	0	11,792	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-MEDI CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 11:53 am
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1.00	2.00	3.00	4.00	1.00
Hospital and Hospital Health Care Complex Address:				
1.00	Street: 620 EIGHTH AVENUE	PO Box:		1.00
2.00	City: TERRE HAUTE	State: IN	Zip Code: 47804	2.00
			County: VIGO	

	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	HAMILTON CENTER, INC.	154009	45460	4	11/15/1973	N	P	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									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2020	06/30/2021	20.00
21.00	Type of Control (see instructions)	2		21.00
		1.00	2.00	3.00

Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N							22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N							22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N							22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		N					22.03
22.04	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.									22.04
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations 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)									22.04
22.04	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.									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.				3	N				23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-4009			Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 11:53 am		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
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	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.					1			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00

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		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 adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00
61.01	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
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings 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 Nonprovi- der Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00	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. 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

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	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
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y			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)			N	N	0	71.00
75.00	Inpatient Rehabilitation Facility PPS 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

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			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 1.00	XIX 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. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06	
Rural Providers						
105.00	Does this hospital qualify as a CAH?		N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00	
			Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
			1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N		110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 11:53 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	65,702	0	118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 11:53 am			
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:			
142.00	Street:	PO Box:					
143.00	City:	State:		Zip Code:			
				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.				N	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			
165.00	Multi campus Is this hospital part of a Multi campus 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							
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.				N	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				0.00	169.00	
				Beginni ng	Endi ng		
				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	0171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-4009		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part II Date/Time Prepared: 11/29/2021 11:53 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N	A	12/31/2021	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
						Y/N	
						1.00	
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					N	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	09/20/2021	Y	09/20/2021
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/29/2021 11:53 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA		SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946		TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/29/2021 11:53 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 11:53 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / Tri ps	
					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	16	5,840	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		16	5,840	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		16	5,840	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC	99.00				0	25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		16				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: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 11:53 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	975	390	5,117			1.00
2.00 HMO and other (see instructions)	0	368				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	975	390	5,117			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)	975	390	5,117	0.00	527.00	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						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC	0	0	0	0.00	0.00	25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	527.00	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 11:53 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	141	78	973	1.00
2.00 HMO and other (see instructions)				0	74		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		141	78	973	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC	0.00						25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet A
Date/Time Prepared:
11/29/2021 11:53 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		0	0	2,320,030	2,320,030	1.00
3.00	00300		0	0	0	0	3.00
4.00	00400						4.00
5.00	00500	560,979	488,142	1,049,121	0	1,049,121	4.00
5.00	00500	6,706,498	-4,270,456	2,436,042	8,765,030	11,201,072	5.00
7.00	00700	472,104	288,510	760,614	0	760,614	7.00
9.00	00900	185,655	99,849	285,504	0	285,504	9.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	195,745	271,105	466,850	0	466,850	16.00
18.00	01850	0	0	0	0	0	18.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,486,362	3,318,191	4,804,553	-1,304,687	3,499,866	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	67,289	67,289	0	67,289	60.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	124,281	124,281	0	124,281	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	10,283,592	10,903,616	21,187,208	-14,780,483	6,406,725	90.00
OTHER REIMBURSABLE COST CENTERS							
98.00	09850	0	0	0	0	0	98.00
99.00	09900	0	0	0	0	0	99.00
SPECIAL PURPOSE COST CENTERS							
118.00		19,890,935	11,290,527	31,181,462	-5,000,110	26,181,352	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	8,268,059	10,806,447	19,074,506	5,000,110	24,074,616	194.00
194.01	07951	611,277	584,480	1,195,757	0	1,195,757	194.01
200.00		28,770,271	22,681,454	51,451,725	0	51,451,725	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet A
Date/Time Prepared:
11/29/2021 11:53 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-38,330	2,281,700	1.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,049,121	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,226,044	7,975,028	5.00
7.00	00700	OPERATION OF PLANT	0	760,614	7.00
9.00	00900	HOUSEKEEPING	0	285,504	9.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-20,582	446,268	16.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	18.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-920,614	2,579,252	30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	67,289	60.00
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	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	124,281	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-113,648	6,293,077	90.00
OTHER REIMBURSABLE COST CENTERS					
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
99.00	09900	CMHC	0	0	99.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,319,218	21,862,134	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	OTHER NONREIMB COST CENTER	0	24,074,616	194.00
194.01	07951	GRACE CLINIC HEALTH PROFESSIONAL	0	1,195,757	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,319,218	47,132,507	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,928,936	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
TOTALS			0	1,928,936	
B - OVERHEAD ALLOCATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,379,382	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
TOTALS			0	7,379,382	
C - PSYCHIATRY ALLOCATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,990,273	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
TOTALS			0	2,990,273	
D - MRO EXPENSE					
1.00	OTHER NONREIMB COST CENTER	194.00	4,282,126	4,540,307	1.00
TOTALS			4,282,126	4,540,307	
E - INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	391,094	1.00
TOTALS			0	391,094	
500.00	Grand Total: Increases		4,282,126	17,229,992	500.00

RECLASSIFICATIONS

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6

Date/Time Prepared:
11/29/2021 11:53 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - DEPRECIATION EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,213,531	9	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	54,823	0	2.00
3.00	CLINIC	90.00	0	660,582	0	3.00
	TOTALS		0	1,928,936		
B - OVERHEAD ALLOCATION						
1.00	ADULTS & PEDIATRICS	30.00	0	862,922	0	1.00
2.00	CLINIC	90.00	0	3,652,818	0	2.00
3.00	OTHER NONREIMB COST CENTER	194.00	0	2,863,642	0	3.00
	TOTALS		0	7,379,382		
C - PSYCHIATRY ALLOCATION						
1.00	ADULTS & PEDIATRICS	30.00	0	386,942	0	1.00
2.00	CLINIC	90.00	0	1,644,650	0	2.00
3.00	OTHER NONREIMB COST CENTER	194.00	0	958,681	0	3.00
	TOTALS		0	2,990,273		
D - MRO EXPENSE						
1.00	CLINIC	90.00	4,282,126	4,540,307	0	1.00
	TOTALS		4,282,126	4,540,307		
E - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	391,094	9	1.00
	TOTALS		0	391,094		
500.00	Grand Total: Decreases		4,282,126	17,229,992		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-7
Part I
Date/Time Prepared:
11/29/2021 11:53 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,110,263	77,238	0	77,238	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	23,327,769	211,262	0	211,262	0	3.00
4.00	Building Improvements	567,650	539,822	0	539,822	0	4.00
5.00	Fixed Equipment	6,591,108	374,739	0	374,739	0	5.00
6.00	Movable Equipment	3,002,171	320,189	0	320,189	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	36,598,961	1,523,250	0	1,523,250	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	36,598,961	1,523,250	0	1,523,250	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,187,501	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	23,539,031	0				3.00
4.00	Building Improvements	1,107,472	0				4.00
5.00	Fixed Equipment	6,965,847	0				5.00
6.00	Movable Equipment	3,322,360	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	38,122,211	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	38,122,211	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-7
Part II
Date/Time Prepared:
11/29/2021 11:53 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-7
Part III
Date/Time Prepared:
11/29/2021 11:53 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	36,598,962	0	36,598,962	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	36,598,962	0	36,598,962	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	2,281,700	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	2,281,700	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	2,281,700	1.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,281,700	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/29/2021 11:53 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
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	*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)	B	-38,330	0	CAP REL COSTS-BLDG & FIXT	1.00	9	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	-2,584,382	0		0.00	0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-20,582	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)	B	-308	0	ADMINISTRATIVE & GENERAL	5.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 ADVERTISING	A	-12,599	0	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/29/2021 11:53 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.01 PUBLIC RELATIONS	A		0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.01
33.02 PUBLIC RELATIONS	A	-15,495		ADMINISTRATIVE & GENERAL	5.00	0 33.02
33.03 PUBLIC RELATIONS	A		0	ADULTS & PEDIATRICS	30.00	0 33.03
33.04 PUBLIC RELATIONS	A	-157		CLINIC	90.00	0 33.04
33.05 REPRESENTATIVE PAYEE FEES	B	-52,941		ADMINISTRATIVE & GENERAL	5.00	0 33.05
33.06 WABASH VALLEY HEALTH CENTER INCOME	B	-42,401		ADMINISTRATIVE & GENERAL	5.00	0 33.06
33.07 MISC INCOME	B	-154,483		ADMINISTRATIVE & GENERAL	5.00	0 33.07
33.08 BOARD OF DIRECTOR FEES	B			ADMINISTRATIVE & GENERAL	5.00	0 33.08
33.09 ADVERTISING	A		0	CLINIC	90.00	0 33.09
33.11 MISC INCOME	B		0	CLINIC	90.00	0 33.11
33.12 WABASH VALLEY HEALTH CENTER INCOME	B	-73,701		CLINIC	90.00	0 33.12
33.13 WABASH VALLEY HEALTH CENTER EAP	B		0	ADMINISTRATIVE & GENERAL	5.00	0 33.13
33.14 MARKETING	A	-326,480		ADMINISTRATIVE & GENERAL	5.00	0 33.14
33.15 XIX HOSPITAL ASSESSMENT FEE A/C 9312	A	-920,242		ADULTS & PEDIATRICS	30.00	0 33.15
33.16 DONATION EXPENSE	A		0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.16
33.17 DONATION EXPENSE	A	-36,955		ADMINISTRATIVE & GENERAL	5.00	0 33.17
33.18 DONATION EXPENSE	A		0	OPERATION OF PLANT	7.00	0 33.18
33.19 DONATION EXPENSE	A	-372		ADULTS & PEDIATRICS	30.00	0 33.19
33.20 DONATION EXPENSE	A	-1,844		CLINIC	90.00	0 33.20
33.21 SCHOOL BASED SERVICES	B	-22,917		CLINIC	90.00	0 33.21
33.22 SCHOOL SERVICES C&A AND GREENE COUNT	B		0	CLINIC	90.00	0 33.22
33.23 PROJ-CHILD & ADOLESCENT SERVICES	B	-14,829		CLINIC	90.00	0 33.23
33.24 MISC INCOME PUTNAM COUNTY	B	-200		CLINIC	90.00	0 33.24
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,319,218				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-2

Date/Time Prepared:
11/29/2021 11:53 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	1,093,699	1,093,699	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	1,490,683	1,490,683	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,584,382	2,584,382	0	0	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	1,093,699		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	1,490,683		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,584,382		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
		BLDG & FIXT				
	0	1.00	4.00	4A	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,281,700	2,281,700			1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,049,121	46,716	1,095,837		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	7,975,028	906,454	260,527	9,142,009	5.00
7.00 00700	OPERATION OF PLANT	760,614	254,959	18,340	1,033,913	7.00
9.00 00900	HOUSEKEEPING	285,504	0	7,212	292,716	9.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	446,268	84,782	7,604	538,654	16.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,579,252	576,994	57,741	3,213,987	30.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	67,289	41	0	67,330	60.00
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	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	124,281	41	0	124,322	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	6,293,077	411,713	233,139	6,937,929	90.00
OTHER REIMBURSABLE COST CENTERS						
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
99.00 09900	CMHC	0	0	0	0	99.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	21,862,134	2,281,700	584,563	21,350,860	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	OTHER NONREIMB COST CENTER	24,074,616	0	487,528	24,562,144	194.00
194.01 07951	GRACE CLINIC HEALTH PROFESSIONAL	1,195,757	0	23,746	1,219,503	194.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	47,132,507	2,281,700	1,095,837	47,132,507	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT	HOUSEKEEPING	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		7.00	9.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	1,282,713				7.00
9.00	00900	HOUSEKEEPING	0	363,155			9.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0		14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	101,299	28,679	0	0	16.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	798,253	18.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	689,397	195,179	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	49	14	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,918	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49	14	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	491,919	139,269	0	0	90.00
OTHER REIMBURSABLE COST CENTERS							
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	99.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,282,713	363,155	0	0	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER NONREIMB COST CENTER	0	0	0	0	194.00
194.01	07951	GRACE CLINIC HEALTH PROFESSIONAL	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,282,713	363,155	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet B
Part I
Date/Time Prepared:
11/29/2021 11:53 am

Cost Center Description	OTHER GENERAL SERVICE (SPECIFY)	PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	18.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
7.00 00700	OPERATION OF PLANT					7.00
9.00 00900	HOUSEKEEPING					9.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0				18.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0	5,111,980	0	5,111,980 30.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	87,513	0	87,513 60.00
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	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	161,539	0	161,539 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	9,785,745	0	9,785,745 90.00
OTHER REIMBURSABLE COST CENTERS						
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
99.00 09900	CMHC	0	0	0	0	99.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	15,146,777	0	15,146,777 118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	OTHER NONREIMB COST CENTER	0	0	30,472,767	0	30,472,767 194.00
194.01 07951	GRACE CLINIC HEALTH PROFESSIONAL	0	0	1,512,963	0	1,512,963 194.01
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	0	47,132,507	0	47,132,507 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet B
Part II
Date/Time Prepared:
11/29/2021 11:53 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	46,716	46,716	46,716		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	906,454	906,454	11,106	917,560	5.00
7.00 00700	OPERATION OF PLANT	0	254,959	254,959	782	24,971	7.00
9.00 00900	HOUSEKEEPING	0	0	0	307	7,070	9.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	84,782	84,782	324	13,010	16.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	576,994	576,994	2,461	77,624	30.00
ANCILLARY SERVICE COST CENTERS							
54.00 05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
60.00 06000	LABORATORY	0	41	41	0	1,626	60.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	41	41	0	3,003	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	411,713	411,713	9,938	167,565	90.00
OTHER REIMBURSABLE COST CENTERS							
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00 09900	CMHC	0	0	0	0	0	99.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	2,281,700	2,281,700	24,918	294,869	118.00
NONREIMBURSABLE COST CENTERS							
194.00 07950	OTHER NONREIMB COST CENTER	0	0	0	20,786	593,238	194.00
194.01 07951	GRACE CLINIC HEALTH PROFESSIONAL	0	0	0	1,012	29,453	194.01
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	2,281,700	2,281,700	46,716	917,560	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT	HOUSEKEEPING	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		7.00	9.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	280,712				7.00
9.00	00900	HOUSEKEEPING	0	7,377			9.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0		14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,168	583	0	0	16.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	150,869	3,965	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	11	0	0	0	60.00
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	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	107,653	2,829	0	0	90.00
OTHER REIMBURSABLE COST CENTERS							
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	99.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	280,712	7,377	0	0	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER NONREIMB COST CENTER	0	0	0	0	194.00
194.01	07951	GRACE CLINIC HEALTH PROFESSIONAL	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	280,712	7,377	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	OTHER GENERAL SERVICE (SPECIFY)	PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	18.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
7.00 00700	OPERATION OF PLANT					7.00
9.00 00900	HOUSEKEEPING					9.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0				18.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0		848,253	0	848,253 30.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY - DIAGNOSTIC	0		0	0	54.00
60.00 06000	LABORATORY	0		2,271	0	2,271 60.00
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	0		0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0		4,151	0	4,151 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0		782,536	0	782,536 90.00
OTHER REIMBURSABLE COST CENTERS						
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	98.00
99.00 09900	CMHC	0		0	0	99.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	1,637,211	0	1,637,211 118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	OTHER NONREIMB COST CENTER	0		614,024	0	614,024 194.00
194.01 07951	GRACE CLINIC HEALTH PROFESSIONAL	0		30,465	0	30,465 194.01
200.00	Cross Foot Adjustments		0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	0	2,281,700	0	2,281,700 202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 11:53 am

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5A	5.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	55,924				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,145	28,209,292			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	22,217	6,706,498	-9,142,009	37,990,498	5.00
7.00 00700	OPERATION OF PLANT	6,249	472,104	0	1,033,913	7.00
9.00 00900	HOUSEKEEPING	0	185,655	0	292,716	9.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,078	195,745	0	538,654	16.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	14,142	1,486,362	0	3,213,987	30.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	1	0	0	67,330	60.00
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	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1	0	0	124,322	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	10,091	6,001,466	0	6,937,929	90.00
OTHER REIMBURSABLE COST CENTERS						
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
99.00 09900	CMHC	0	0	0	0	99.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	55,924	15,047,830	-9,142,009	12,208,851	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	OTHER NONREIMB COST CENTER	0	12,550,185	0	24,562,144	194.00
194.01 07951	GRACE CLINIC HEALTH PROFESSIONAL	0	611,277	0	1,219,503	194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,281,700	1,095,837		9,142,009	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	40.800014	0.038847		0.240639	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		46,716		917,560	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.001656		0.024152	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: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 11:53 am

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	OTHER GENERAL SERVICE (SPECIFY) (TIME SPENT)	
		9.00	14.00	15.00	16.00	18.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
9.00	00900	HOUSEKEEPING	26,313				9.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0			14.00
15.00	01500	PHARMACY	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,078	0	0	19,036,709	16.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,142	0	0	5,723,700	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	1	0	0	93,445	60.00
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	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1	0	0	172,590	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	10,091	0	0	13,046,974	90.00
OTHER REIMBURSABLE COST CENTERS							
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	99.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,313	0	0	19,036,709	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER NONREIMB COST CENTER	0	0	0	0	194.00
194.01	07951	GRACE CLINIC HEALTH PROFESSIONAL	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	363,155	0	0	798,253	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.801353	0.000000	0.000000	0.041932	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,377	0	0	120,867	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.280356	0.000000	0.000000	0.006349	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: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1
Date/Time Prepared:
11/29/2021 11:53 am

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	
		23.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
9.00	00900	HOUSEKEEPING	9.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	18.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY - DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
OTHER REIMBURSABLE COST CENTERS			
98.00	09850	OTHER REIMBURSABLE COST CENTERS	98.00
99.00	09900	CMHC	99.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950	OTHER NONREIMB COST CENTER	194.00
194.01	07951	GRACE CLINIC HEALTH PROFESSIONAL	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet C
Part I
Date/Time Prepared:
11/29/2021 11:53 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		PPS
				Total Costs	RCE Disallowance	Total Costs		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000 ADULTS & PEDIATRICS	5,111,980		5,111,980	0	5,111,980		30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400 RADIOLOGY - DIAGNOSTIC	0		0	0	0		54.00
60.00	06000 LABORATORY	87,513		87,513	0	87,513		60.00
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		0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	161,539		161,539	0	161,539		73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	9,785,745		9,785,745	0	9,785,745		90.00
OTHER REIMBURSABLE COST CENTERS								
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0		98.00
99.00	09900 CMHC	0		0	0	0		99.00
200.00	Subtotal (see instructions)	15,146,777	0	15,146,777	0	15,146,777		200.00
201.00	Less Observation Beds	0		0	0	0		201.00
202.00	Total (see instructions)	15,146,777	0	15,146,777	0	15,146,777		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet C
Part I
Date/Time Prepared:
11/29/2021 11:53 am

Cost Center Description		Title XVIII			Hospital	PPS	
		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,723,700		5,723,700		30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	93,445	0	93,445	0.936519	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	172,590	0	172,590	0.935970	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	13,046,974	13,046,974	0.750039	90.00
OTHER REIMBURSABLE COST CENTERS							
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
99.00	09900	CMHC	0	0	0		99.00
200.00		Subtotal (see instructions)	5,989,735	13,046,974	19,036,709		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	5,989,735	13,046,974	19,036,709		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/29/2021 11:53 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.936519		60.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.935970		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.750039		90.00
OTHER REIMBURSABLE COST CENTERS				
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
99.00	09900 CMHC			99.00
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: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet C
Part I
Date/Time Prepared:
11/29/2021 11:53 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Hospital		Total Costs	
				Costs			
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	5,111,980		5,111,980	0	5,111,980	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY - DIAGNOSTIC	0		0	0	0	54.00
60.00	06000 LABORATORY	87,513		87,513	0	87,513	60.00
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		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	161,539		161,539	0	161,539	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	9,785,745		9,785,745	0	9,785,745	90.00
OTHER REIMBURSABLE COST CENTERS							
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
99.00	09900 CMHC	0		0	0	0	99.00
200.00	Subtotal (see instructions)	15,146,777	0	15,146,777	0	15,146,777	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	15,146,777	0	15,146,777	0	15,146,777	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet C
Part I
Date/Time Prepared:
11/29/2021 11:53 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,723,700		5,723,700		30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	93,445	0	93,445	0.936519	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	172,590	0	172,590	0.935970	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	13,046,974	13,046,974	0.750039	90.00
OTHER REIMBURSABLE COST CENTERS							
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
99.00	09900	CMHC	0	0	0		99.00
200.00		Subtotal (see instructions)	5,989,735	13,046,974	19,036,709		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	5,989,735	13,046,974	19,036,709		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/29/2021 11:53 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital
		11.00		Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
OTHER REIMBURSABLE COST CENTERS				
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
99.00	09900 CMHC			99.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-4009		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part I Date/Time Prepared: 11/29/2021 11:53 am	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	848,253	0	848,253	5,117	165.77	30.00
200.00	Total (lines 30 through 199)	848,253		848,253	5,117		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	975	161,626				
200.00	Total (lines 30 through 199)	975	161,626				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Prepared: 11/29/2021 11:53 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0.000000	0	0	54.00
60.00	06000	LABORATORY	2,271	93,445	0.024303	9,287	226	60.00
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	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,151	172,590	0.024051	19,370	466	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	782,536	13,046,974	0.059978	0	0	90.00
OTHER REIMBURSABLE COST CENTERS								
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50 through 199)	788,958	13,313,009		28,657	692	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-4009		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/29/2021 11:53 am		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	5,117	0.00	975	30.00	
200.00		Total (lines 30 through 199)	0	0	5,117		975	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Prepared: 11/29/2021 11:53 am
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Cost Center Description	Title XVIII					Allied Health	Allied Health	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Hospital			
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	0	60.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	0	0	0	0	0	0	90.00
OTHER REIMBURSABLE COST CENTERS								
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
200.00	Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Prepared: 11/29/2021 11:53 am
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0.000000	54.00
60.00 06000	LABORATORY	0	0	93,445	0.000000	60.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	172,590	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	13,046,974	0.000000	90.00
OTHER REIMBURSABLE COST CENTERS						
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
200.00	Total (lines 50 through 199)	0	0	13,313,009		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 11:53 am

Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000	0	0	0	0 54.00
60.00	06000	LABORATORY	0.000000	9,287	0	0	0 60.00
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	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	19,370	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	660,255	0 90.00
OTHER REIMBURSABLE COST CENTERS							
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0 98.00
200.00		Total (lines 50 through 199)		28,657	0	660,255	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Prepared: 11/29/2021 11:53 am
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		Title XVIII			Hospital	PPS		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.936519	0	0	0	0	60.00
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	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.935970	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.750039	660,255	0	0	495,217	90.00
OTHER REIMBURSABLE COST CENTERS								
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		660,255	0	0	495,217	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		660,255	0	0	495,217	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Prepared: 11/29/2021 11:53 am
Title XVIII		Hospital	PPS

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				
54.00 05400	RADIOLOGY - DIAGNOSTIC	0	0	54.00
60.00 06000	LABORATORY	0	0	60.00
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	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000	CLINIC	0	0	90.00
OTHER REIMBURSABLE COST CENTERS				
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 11:53 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,117	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,117	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,117	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		975	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,111,980	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,111,980	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,111,980	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)		999.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		974,045	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)		974,045	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 11:53 am
Cost Center Description			Title XVIII	Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				26,827
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				1,000,872
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				161,626
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				692
52.00	Total Program excludable cost (sum of lines 50 and 51)				162,318
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				838,554
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0
55.00	Target amount per discharge				0.00
56.00	Target amount (line 54 x line 55)				0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0
58.00	Bonus payment (see instructions)				0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00
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
62.00	Relief payment (see instructions)				0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-4009		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/29/2021 11:53 am	
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	848,253	5,111,980	0.165934	0	0	90.00
91.00	Nursing School cost	0	5,111,980	0.000000	0	0	91.00
92.00	Allied health cost	0	5,111,980	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,111,980	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 11/29/2021 11:53 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,117	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,117	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,117	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		390	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,111,980	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,111,980	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,111,980	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)		999.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		389,618	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)		389,618	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 11:53 am
Cost Center Description			Title XIX	Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				389,618 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)				0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-4009		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/29/2021 11:53 am	
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	848,253	5,111,980	0.165934	0	0	90.00
91.00	Nursing School cost	0	5,111,980	0.000000	0	0	91.00
92.00	Allied health cost	0	5,111,980	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,111,980	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 11:53 am	
Cost Center Description		Ratio of Cost To Charges	Hospital	PPS	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,174,800		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000 LABORATORY	0.936519	9,287	8,697	60.00
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	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.935970	19,370	18,130	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.750039	0	0	90.00
OTHER REIMBURSABLE COST CENTERS					
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)		28,657	26,827	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		28,657		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 11:53 am	
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		472,063		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000 LABORATORY	0.936519	0	0	60.00
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	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.935970	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.750039	0	0	90.00
OTHER REIMBURSABLE COST CENTERS					
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)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/29/2021 11:53 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		495,217	2.00
3.00	OPPS payments		510,495	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)		0	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 charge basis 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)		0	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)		510,495	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		130,889	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)		379,606	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)		379,606	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		379,606	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		379,606	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)		0	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)		379,606	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		0	40.03
41.00	Interim payments		379,606	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	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: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet E-1
Part I
Date/Time Prepared:
11/29/2021 11:53 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		674,116		379,606	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)		674,116		379,606	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		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		674,116		379,606	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part II Date/Time Prepared: 11/29/2021 11:53 am
		Title XVIII	Hospital	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		800,975	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		14.019178	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line } 8/\text{line } 9)) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		800,975	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		800,975	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		800,975	18.00
19.00	Deductibles		114,920	19.00
20.00	Subtotal (line 18 minus line 19)		686,055	20.00
21.00	Coinsurance		11,939	21.00
22.00	Subtotal (line 20 minus line 21)		674,116	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		674,116	26.00
27.00	Direct graduate medical education payments (see instructions)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		674,116	31.00
31.01	Sequestration adjustment (see instructions)		0	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		674,116	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-4009	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/29/2021 11:53 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		389,618		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)		389,618	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)		389,618	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		472,063		8.00
9.00	Ancillary service charges		0	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)		472,063	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)		472,063	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		82,445	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)		389,618	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)		389,618	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)		389,618	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		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)		389,618	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		389,618	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)		389,618	0	40.00
41.00	Interim payments		377,826	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		11,792	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: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet G

Date/Time Prepared:
11/29/2021 11:53 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	5,814,426	0	0	0	1.00
2.00	Temporary investments	17,828,426	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,210,222	0	0	0	4.00
5.00	Other receivable	1,111,413	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	483,948	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	32,448,435	0	0	0	11.00
FIXED ASSETS						
12.00	Land	11,288,985	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	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	164,759	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)	11,453,744	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	380,471	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	2,337,478	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,717,949	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	46,620,128	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	580,087	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,564,727	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	261,928	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,078,274	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,485,016	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	552,881	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	552,881	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,037,897	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	38,582,231				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)	38,582,231	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	46,620,128	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-1

Date/Time Prepared:
11/29/2021 11:53 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		38,456,262		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		125,969				2.00
3.00	Total (sum of line 1 and line 2)		38,582,231		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		38,582,231		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)		38,582,231		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2021 11:53 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	5,723,700		5,723,700	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)	5,723,700		5,723,700	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,723,700		5,723,700	17.00
18.00	Ancillary services	266,035		266,035	18.00
19.00	Outpatient services	0	13,046,974	13,046,974	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	682,380	3,916,488	4,598,868	27.00
27.01	PHYSICIANS' PRIVATE OFFICES	0	0	0	27.01
27.02	RESIDENTIAL	0	15,746,334	15,746,334	27.02
27.03	CSP	0	0	0	27.03
27.04	MRO	0	12,103,658	12,103,658	27.04
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,672,115	44,813,454	51,485,569	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		51,451,725		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)		51,451,725		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-4009

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-3

Date/Time Prepared:
11/29/2021 11:53 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	51,485,569	1.00
2.00	Less contractual allowances and discounts on patients' accounts	22,522,082	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,963,487	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	51,451,725	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-22,488,238	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	INTEREST INCOME	0	24.00
24.01	GRANTS	11,287,296	24.01
24.02	COUNTY TAX LEVY	1,358,181	24.02
24.03	CONTRIBUTIONS	99,200	24.03
24.04	NET UNREALIZED ON INVESTMENT	3,863,360	24.04
24.05	INTEREST INCOME WITH DONOR RESTR.	-1,161,642	24.05
24.06	CONTRIBUTIONS WITH DONOR RESTR.	86,114	24.06
24.07	NET REALIZED GAIN ON INVEST	236,435	24.07
24.08	NET UNREALIZED GAIN ON INVEST	-138,347	24.08
24.09	MENTAL HEALTH FUNDS RECOVERY	5,292,525	24.09
24.10	GAIN ON SALE ON DISPOSITION OF ASSET	18,486	24.10
24.11	NET ASSETS RELEASED FROM DONOR RESTR	0	24.11
24.12	OTHER INCOME	758,803	24.12
24.50	COVID-19 PHE Funding	913,796	24.50
25.00	Total other income (sum of lines 6-24)	22,614,207	25.00
26.00	Total (line 5 plus line 25)	125,969	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	125,969	29.00