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: 15-0097	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/27/2022 10:37 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/27/2022 Time: 10:37 am
2. [ ] Manually prepared cost report
3. [1] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MAJOR HOSPITAL (15-0097) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	349,817	-46,342	0	-347,108	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		1,737		0	10.00
10.01	RURAL HEALTH CLINIC II	0		19,863		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-265,994		0	10.02
200.00	Total	0	349,817	-290,736	0	-347,108	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 10:37 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2451 INTELLIPLEX DR	PO Box:			1.00
2.00	City: SHELBYVILLE	State: IN	Zip Code: 46176-	County: SHELBY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	MAJOR HOSPITAL	150097	26900	1	07/01/1966	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	MHP PEDIATRICS	158529	99915		01/29/2018	N	N	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	MHP OB/GYN	158531	99915		01/29/2018	N	N	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	MHP FAMILY & INTERNAL MEDICINE	158532	99915		01/29/2018	N	N	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2021	12/31/2021	20.00
21.00	Type of Control (see instructions)	8		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2022 10:37 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.	347	764	0	0	1,664	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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)	Y	Y	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	Y	40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 10:37 am

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

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 10:37 am

				V	XIX	
				1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00
		1.00	2.00	3.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	328,216	0	0		118.01
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		Y	5.00		122.00
	Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2022 10:37 am

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

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		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)	9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0097	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 10:37 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2022 10:37 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/03/2022	Y	03/03/2022	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2022 10:37 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMITH@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0097	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/27/2022 10:37 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.	SENIOR 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: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2022 10:37 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	40	14,600	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)		40	14,600	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		46	16,790	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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		46				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: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2022 10:37 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)	2,923	345	8,877			1.00
2.00	HMO and other (see instructions)	3,248	2,372				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)	2,923	345	8,877			7.00
8.00	INTENSIVE CARE UNIT	532	0	2,309			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)	3,455	345	11,186	0.00	705.90	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			3			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	66	12,144	21,725	0.00	24.36	26.00
26.01	RURAL HEALTH CLINIC II	267	1,008	6,645	0.00	11.79	26.01
26.02	RURAL HEALTH CLINIC III	15,440	2,809	61,660	0.00	89.70	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	831.75	27.00
28.00	Observation Bed Days		13	847			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	58	84			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: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2022 10:37 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	858	66	2,614	1.00
2.00	HMO and other (see instructions)			741	576		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	858	66	2,614	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part II Date/Time Prepared: 5/27/2022 10:37 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	61,173,143	-452,851	60,720,292	1,712,196.96	35.46	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		585,883	0	585,883	2,968.00	197.40	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		2,356,848	0	2,356,848	12,111.00	194.60	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		7,255,565	0	7,255,565	261,719.48	27.72	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,351,968	66,317	3,418,285	58,566.03	58.37	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		225,853	0	225,853	4,117.00	54.86	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		360,868	0	360,868	1,535.00	235.09	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		12,627,657	0	12,627,657			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		914,898	0	914,898			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		155,748	0	155,748			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		629,497	0	629,497			23.00
24.00	Wage-related costs (RHC/FQHC)		1,946,892	0	1,946,892			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part II Date/Time Prepared: 5/27/2022 10:37 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	515,670	-3,909	511,761	12,153.08	42.11	26.00
27.00	Administrative & General	5.00	9,479,235	-146,083	9,333,152	268,893.35	34.71	27.00
28.00	Administrative & General under contract (see inst.)		789,751	0	789,751	2,437.00	324.07	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,300,964	-11,231	1,289,733	44,436.02	29.02	30.00
31.00	Laundry & Linen Service	8.00	133,386	-756	132,630	6,448.92	20.57	31.00
32.00	Housekeeping	9.00	1,724,081	-10,664	1,713,417	81,954.93	20.91	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	892,323	-619,730	272,593	15,568.12	17.51	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	610,617	610,617	33,746.00	18.09	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	955,109	-5,363	949,746	17,105.82	55.52	38.00
39.00	Central Services and Supply	14.00	297,288	-297,288	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,251,561	-4,466	1,247,095	26,430.31	47.18	40.00
41.00	Medical Records & Medical Records Library	16.00	1,422,195	-2,734	1,419,461	56,149.08	25.28	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part III Date/Time Prepared: 5/27/2022 10:37 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		52,350,481	-452,851	51,897,630	1,440,803.48	36.02	1.00
2.00	Excluded area salaries (see instructions)		3,351,968	66,317	3,418,285	58,566.03	58.37	2.00
3.00	Subtotal salaries (line 1 minus line 2)		48,998,513	-519,168	48,479,345	1,382,237.45	35.07	3.00
4.00	Subtotal other wages & related costs (see inst.)		586,721	0	586,721	5,652.00	103.81	4.00
5.00	Subtotal wage-related costs (see inst.)		12,783,405	0	12,783,405	0.00	26.37	5.00
6.00	Total (sum of lines 3 thru 5)		62,368,639	-519,168	61,849,471	1,387,889.45	44.56	6.00
7.00	Total overhead cost (see instructions)		18,761,563	-491,607	18,269,956	565,322.63	32.32	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part IV Date/Time Prepared: 5/27/2022 10:37 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	3,444,419	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	8,777,024	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	51,405	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	86,585	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	667,167	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	106,863	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	3,347,069	17.00
18.00	Medicare Taxes - Employers Portion Only	851,252	18.00
19.00	Unemployment Insurance	32,850	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	10,444	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	17,375,078	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part V | Date/Time Prepared: 5/27/2022 10:37 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	225,853	13,528,082	1.00
2.00	Hospital	225,853	13,528,082	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0097 | Component CCN: 15-8529 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/27/2022 10:37 am

RHC I

				1.00		
	Clinic Address and Identification					
1.00	Street			2451 INTELLIPLEX DRIVE, SUITE 240		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	SHELBYVILLE		IN	46176	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:30	17:00	07:30	11.00

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	07:30	17:00	07:30	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0097
Component CCN: 15-8529

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

Worksheet S-8

Date/Time Prepared:
5/27/2022 10:37 am

RHC I

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0097 | Component CCN: 15-8531 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/27/2022 10:37 am

RHC II

					1.00	
	Clinic Address and Identification					
1.00	Street				2451 INTELLIPLEX DRIVE, SUITE 230	1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	SHELBYVILLE		IN	46176	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0097 | Component CCN: 15-8531 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/27/2022 10:37 am

RHC II

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0097 | Component CCN: 15-8532 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/27/2022 10:37 am

RHC III

					1.00	
	Clinic Address and Identification					
1.00	Street				2451 INTELLIPLEX DRIVE, SUITE 260	1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	SHELBYVILLE		IN	46176	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	17:00	07:00	11.00

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	07:00	17:00	07:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0097 | Component CCN: 15-8532 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/27/2022 10:37 am

RHC III

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-10 | Date/Time Prepared: 5/27/2022 10:37 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.262950	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	9,366,274	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	77,388,947	6.00
7.00	Medicaid cost (line 1 times line 6)	20,349,424	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	10,983,150	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	10,983,150	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	5,994,628	1,022,644	7,017,272	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,576,287	1,022,644	2,598,931	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,576,287	1,022,644	2,598,931	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	8,109,861	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	202,920	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	312,185	27.01
28.00	Non-Medicare bad debt expense (see instructions)	7,797,676	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,159,664	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,758,595	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	15,741,745	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/27/2022 10:37 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		16,139,645	16,139,645	0	16,139,645	1.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	515,670	11,719,188	12,234,858	0	12,234,858	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,479,235	21,907,170	31,386,405	-269,175	31,117,230	5.00
7.00	00700	OPERATION OF PLANT	1,300,964	1,986,641	3,287,605	0	3,287,605	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	133,386	160,756	294,142	0	294,142	8.00
9.00	00900	HOUSEKEEPING	1,724,081	1,127,885	2,851,966	0	2,851,966	9.00
10.00	01000	DIETARY	892,323	1,259,121	2,151,444	-1,480,737	670,707	10.00
11.00	01100	CAFETERIA	0	0	0	1,480,737	1,480,737	11.00
13.00	01300	NURSING ADMINISTRATION	955,109	530,926	1,486,035	0	1,486,035	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	297,288	408,560	705,848	-702,090	3,758	14.00
15.00	01500	PHARMACY	1,251,561	12,090,893	13,342,454	0	13,342,454	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,422,195	439,538	1,861,733	0	1,861,733	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,705,251	1,445,152	8,150,403	19,280	8,169,683	30.00
31.00	03100	INTENSIVE CARE UNIT	2,428,488	550,421	2,978,909	0	2,978,909	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,620,669	4,484,057	7,104,726	-1,601,874	5,502,852	50.00
53.00	05300	ANESTHESIOLOGY	3,016,564	256,692	3,273,256	0	3,273,256	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,201,972	2,519,516	5,721,488	0	5,721,488	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	1,417,113	977,932	2,395,045	0	2,395,045	56.01
57.00	05700	CT SCAN	382,769	436,737	819,506	0	819,506	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	452,863	338,860	791,723	0	791,723	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,252,305	5,168,500	7,420,805	0	7,420,805	60.00
65.00	06500	RESPIRATORY THERAPY	1,369,230	277,838	1,647,068	0	1,647,068	65.00
65.01	06501	SLEEP LAB	434,642	144,321	578,963	0	578,963	65.01
66.00	06600	PHYSICAL THERAPY	1,943,937	234,822	2,178,759	0	2,178,759	66.00
69.00	06900	ELECTROCARDIOLOGY	739,120	1,663,175	2,402,295	0	2,402,295	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,995,353	1,995,353	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,330,017	1,369,116	2,699,133	61,926	2,761,059	88.00
88.01	08801	RURAL HEALTH CLINIC II	605,323	1,140,573	1,745,896	0	1,745,896	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,320,225	4,862,512	10,182,737	0	10,182,737	88.02
90.00	09000	CLINIC	1,425,743	1,197,474	2,623,217	0	2,623,217	90.00
91.00	09100	EMERGENCY	2,865,731	1,478,012	4,343,743	289,331	4,633,074	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,337,401	344,301	1,681,702	0	1,681,702	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	57,821,175	96,660,334	154,481,509	-207,249	154,274,260	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	UROLOGY	12,515	35,112	47,627	0	47,627	190.01
190.05	19005	MARKETING	0	0	0	269,175	269,175	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	63,284	73,485	136,769	0	136,769	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	11,592	25,225	36,817	0	36,817	190.09
190.11	19011	MHP ADMIN BUILDING	37,227	35,612	72,839	0	72,839	190.11
190.16	19016	RENOVO	41,822	60,462	102,284	0	102,284	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	3,015,741	532,260	3,548,001	-61,926	3,486,075	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	0	0	0	0	0	192.02
194.00	07950	UNAVIE	169,787	37,140	206,927	0	206,927	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	61,173,143	97,459,630	158,632,773	0	158,632,773	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/27/2022 10:37 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	-2,942,900	13,196,745		1.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-9,315	12,225,543		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-13,317,994	17,799,236		5.00
7.00	00700	OPERATION OF PLANT	0	3,287,605		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	294,142		8.00
9.00	00900	HOUSEKEEPING	-2,123	2,849,843		9.00
10.00	01000	DIETARY	-29,067	641,640		10.00
11.00	01100	CAFETERIA	-286,528	1,194,209		11.00
13.00	01300	NURSING ADMINISTRATION	-627	1,485,408		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,758		14.00
15.00	01500	PHARMACY	0	13,342,454		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,861,733		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-4,144	8,165,539		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,978,909		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-13,978	5,488,874		50.00
53.00	05300	ANESTHESIOLOGY	-3,184,071	89,185		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,038,867	4,682,621		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	05601	ONCOLOGY	-207,843	2,187,202		56.01
57.00	05700	CT SCAN	-56,124	763,382		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	791,723		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-144,385	7,276,420		60.00
65.00	06500	RESPIRATORY THERAPY	-255	1,646,813		65.00
65.01	06501	SLEEP LAB	0	578,963		65.01
66.00	06600	PHYSICAL THERAPY	-72,045	2,106,714		66.00
69.00	06900	ELECTROCARDIOLOGY	-78,400	2,323,895		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,995,353		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	769,835	3,530,894		88.00
88.01	08801	RURAL HEALTH CLINIC II	46,157	1,792,053		88.01
88.02	08802	RURAL HEALTH CLINIC III	2,011,161	12,193,898		88.02
90.00	09000	CLINIC	-812,981	1,810,236		90.00
91.00	09100	EMERGENCY	-804,127	3,828,947		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	1,681,702		92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-20,178,621	134,095,639		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	UROLOGY	0	47,627		190.01
190.05	19005	MARKETING	0	269,175		190.05
190.07	19007	I-74 CAMPUS	0	0		190.07
190.08	19008	RAMPART	0	136,769		190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	36,817		190.09
190.11	19011	MHP ADMIN BUILDING	0	72,839		190.11
190.16	19016	RENOVO	0	102,284		190.16
190.17	19017	IMA	0	0		190.17
190.18	19018	MD SOLUTIONS	0	0		190.18
190.19	19019	MHCD	0	0		190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	HOSPITALIST	0	3,486,075		192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	0	0		192.02
194.00	07950	UNAVIE	0	206,927		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-20,178,621	138,454,152		200.00

RECLASSIFICATIONS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/27/2022 10:37 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	610,617	870,120		1.00
	0		610,617	870,120		
	B - CS&R OTHER					
1.00	ADULTS & PEDIATRICS	30.00	8,061	11,219		1.00
2.00	OPERATING ROOM	50.00	164,506	228,973		2.00
3.00	EMERGENCY	91.00	120,963	168,368		3.00
	0		293,530	408,560		
	C - MARKETING					
1.00	MARKETING	190.05	112,691	156,484		1.00
	0		112,691	156,484		
	D - IMPLANTABLE DEVICES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	97,864	1,897,489		1.00
	0		97,864	1,897,489		
	E - RHC RECLASS					
1.00	RURAL HEALTH CLINIC	88.00	0	61,926		1.00
	0		0	61,926		
	F - SHORT TERM DISABILITY RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,909		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	33,392		2.00
3.00	OPERATION OF PLANT	7.00	0	11,231		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	756		4.00
5.00	HOUSEKEEPING	9.00	0	10,664		5.00
6.00	DIETARY	10.00	0	9,113		6.00
7.00	NURSING ADMINISTRATION	13.00	0	5,363		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,758		8.00
9.00	PHARMACY	15.00	0	4,466		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,734		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	49,550		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	14,921		12.00
13.00	OPERATING ROOM	50.00	0	42,310		13.00
14.00	ANESTHESIOLOGY	53.00	0	132		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	23,828		15.00
16.00	ONCOLOGY	56.01	0	7,813		16.00
17.00	CT SCAN	57.00	0	1,252		17.00
18.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,758		18.00
19.00	LABORATORY	60.00	0	12,344		19.00
20.00	RESPIRATORY THERAPY	65.00	0	294		20.00
21.00	PHYSICAL THERAPY	66.00	0	13,234		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	2,932		22.00
23.00	RURAL HEALTH CLINIC	88.00	0	26,195		23.00
24.00	RURAL HEALTH CLINIC II	88.01	0	11,170		24.00
25.00	RURAL HEALTH CLINIC III	88.02	0	72,040		25.00
26.00	CLINIC	90.00	0	14,129		26.00
27.00	EMERGENCY	91.00	0	16,024		27.00
28.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	11,165		28.00
29.00	RAMPART	190.08	0	317		29.00
30.00	RENOVO	190.16	0	5,747		30.00
31.00	HOSPITALIST	192.01	0	36,400		31.00
32.00	UNAVIE	194.00	0	3,910		32.00
	TOTALS		0	452,851		
500.00	Grand Total: Increases		1,114,702	3,847,430		500.00

RECLASSIFICATIONS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/27/2022 10:37 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA					
1.00	DIETARY	10.00	610,617	870,120	0	1.00
	0		610,617	870,120		
	B - CS&R OTHER					
1.00	CENTRAL SERVICES & SUPPLY	14.00	293,530	408,560	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	0		293,530	408,560		
	C - MARKETING					
1.00	ADMINISTRATIVE & GENERAL	5.00	112,691	156,484	0	1.00
	0		112,691	156,484		
	D - IMPLANTABLE DEVICES RECLASS					
1.00	OPERATING ROOM	50.00	97,864	1,897,489	0	1.00
	0		97,864	1,897,489		
	E - RHC RECLASS					
1.00	HOSPITALIST	192.01	0	61,926	0	1.00
	0		0	61,926		
	F - SHORT TERM DISABILITY RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	3,909	0	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	33,392	0	0	2.00
3.00	OPERATION OF PLANT	7.00	11,231	0	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	756	0	0	4.00
5.00	HOUSEKEEPING	9.00	10,664	0	0	5.00
6.00	DIETARY	10.00	9,113	0	0	6.00
7.00	NURSING ADMINISTRATION	13.00	5,363	0	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	3,758	0	0	8.00
9.00	PHARMACY	15.00	4,466	0	0	9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	2,734	0	0	10.00
11.00	ADULTS & PEDIATRICS	30.00	49,550	0	0	11.00
12.00	INTENSIVE CARE UNIT	31.00	14,921	0	0	12.00
13.00	OPERATING ROOM	50.00	42,310	0	0	13.00
14.00	ANESTHESIOLOGY	53.00	132	0	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	23,828	0	0	15.00
16.00	ONCOLOGY	56.01	7,813	0	0	16.00
17.00	CT SCAN	57.00	1,252	0	0	17.00
18.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	1,758	0	0	18.00
19.00	LABORATORY	60.00	12,344	0	0	19.00
20.00	RESPIRATORY THERAPY	65.00	294	0	0	20.00
21.00	PHYSICAL THERAPY	66.00	13,234	0	0	21.00
22.00	ELECTROCARDIOLOGY	69.00	2,932	0	0	22.00
23.00	RURAL HEALTH CLINIC	88.00	26,195	0	0	23.00
24.00	RURAL HEALTH CLINIC II	88.01	11,170	0	0	24.00
25.00	RURAL HEALTH CLINIC III	88.02	72,040	0	0	25.00
26.00	CLINIC	90.00	14,129	0	0	26.00
27.00	EMERGENCY	91.00	16,024	0	0	27.00
28.00	OBSERVATION BEDS (DISTINCT PART)	92.01	11,165	0	0	28.00
29.00	RAMPART	190.08	317	0	0	29.00
30.00	RENOVO	190.16	5,747	0	0	30.00
31.00	HOSPITALIST	192.01	36,400	0	0	31.00
32.00	UNAVIE	194.00	3,910	0	0	32.00
	TOTALS		452,851	0		
500.00	Grand Total: Decreases		1,567,553	3,394,579		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I Date/Time Prepared: 5/27/2022 10:37 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,900,662	0	0	0	0	1.00
2.00	Land Improvements	12,298,052	0	0	0	0	2.00
3.00	Buildings and Fixtures	128,903,484	13,786,633	0	13,786,633	0	3.00
4.00	Building Improvements	268,012	0	0	0	3,850	4.00
5.00	Fixed Equipment	4,650,236	1,195,974	0	1,195,974	0	5.00
6.00	Movable Equipment	62,862,730	0	0	0	3,586,757	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	211,883,176	14,982,607	0	14,982,607	3,590,607	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	211,883,176	14,982,607	0	14,982,607	3,590,607	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,900,662	0	1.00
2.00	Land Improvements	12,298,052	0	2.00
3.00	Buildings and Fixtures	142,690,117	0	3.00
4.00	Building Improvements	264,162	0	4.00
5.00	Fixed Equipment	5,846,210	0	5.00
6.00	Movable Equipment	59,275,973	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	223,275,176	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	223,275,176	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II Date/Time Prepared: 5/27/2022 10:37 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	16,139,645	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	16,139,645	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	16,139,645		1.00
3.00	Total (sum of lines 1-2)	0	16,139,645		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III Date/Time Prepared: 5/27/2022 10:37 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	163,999,203	0	163,999,203	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	163,999,203	0	163,999,203	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	16,121,645	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	16,121,645	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	-2,924,900	0	0	0	13,196,745	1.00
3.00	Total (sum of lines 1-2)	-2,924,900	0	0	0	13,196,745	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/27/2022 10:37 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-2,924,900	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,402	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,085,844			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	2,862,180			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	A	-286,528	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** 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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/27/2022 10:37 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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	MAJ OTHER REVENUES CASH OVER/SHORT	B	-39,994	ADMINISTRATIVE & GENERAL	5.00	0	33.00
35.00	MAJ OTHER REVENUES RENTAL INCOME	B	-18,000	CAP REL COSTS-BLDG & FIXT	1.00	9	35.00
36.00	MAJ TECHNOLOGY SERV CONTRACT LABOR	B	-277,688	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	MAJ PATIENT ACCESS CONTRACT LABOR	B	-7,287	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	MAJ ACCOUNTING CONTRACT LABOR	B	-123,724	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00	MAJ ADMINISTRATION CONTRACT LABOR	B	-239,804	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	MH EDUCATION CLASS REVENUE	B	-17,464	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	MAJ ACCOUNTING VENDOR REBATES	B	-21,395	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	MAJ OTHER REVENUES PURCHASE DISCOUNT	B	-2,082	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	MAJ OTHER REVENUES REAPPOINTMENT FEE	B	-4,428	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	MAJ PATIENT FINANCI PHYSICIAN BILLIN	B	-662,429	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	MAJ ENVIRONMENTAL S OTHER INCOME	B	-2,123	HOUSEKEEPING	9.00	0	45.02
45.03	MAJ FOOD AND NUTRIT OTHER CAFETERIA	B	0	CAFETERIA	11.00	0	45.03
45.04	MAJ PHARMACY VENDOR REBATES	B	0	PHARMACY	15.00	0	45.04
45.05	MAJ OTHER REVENUES XEROX AND COPYING	B	0	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	MAJ INPATIENT-AMU OTHER INCOME	B	0	ADULTS & PEDIATRICS	30.00	0	45.06
45.07	MAJ RESPIRATORY CAR VENDOR REBATES	B	0	RESPIRATORY THERAPY	65.00	0	45.07
45.08	MAJ REHABILATION SE CONTRACT LABOR	B	-66,792	PHYSICAL THERAPY	66.00	0	45.08
45.09	MAJ CARDIAC DISEASE CONTRACT LABOR	B	-56,424	ELECTROCARDIOLOGY	69.00	0	45.09
45.10	MAJ CENTRAL SUPPLY VENDOR REBATES	B	-13,978	OPERATING ROOM	50.00	0	45.10
45.11	MH MHP FIM OTHER INCOME	B	-1,896	RURAL HEALTH CLINIC III	88.02	0	45.11
45.12	MAJ DISEASE MGT CLASS REVENUE	B	-1,100	CLINIC	90.00	0	45.12
45.13	MAJ MEDICAL SPECIAL RENTAL INCOME	B	-193,100	CLINIC	90.00	0	45.13
45.14	MAJ ONSITE SOLUTION OTHER INCOME	B	0	HOME HEALTH AGENCY	101.00	0	45.14
45.15	MAJ OTHER REVENUES OTHER INCOME	B	0	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16	MAJ HOME HEALTH OTHER DISCOUNT	B	-31,836	ADMINISTRATIVE & GENERAL	5.00	0	45.16
45.17	MEALS ON WHEELS	A	-29,067	DIETARY	10.00	0	45.17
45.18	PROMOTIONAL GIFTS	A	-255	RESPIRATORY THERAPY	65.00	0	45.18
45.19	PROMOTIONAL GIFTS	A	-9,546	ADMINISTRATIVE & GENERAL	5.00	0	45.19
45.20	PROMOTIONAL GIFTS	A	0	NURSING ADMINISTRATION	13.00	0	45.20
45.21	PROMOTIONAL GIFTS	A	-4,144	ADULTS & PEDIATRICS	30.00	0	45.21
45.22	PROMOTIONAL GIFTS	A	-163	RADIOLOGY-DIAGNOSTIC	54.00	0	45.22
45.23	PROMOTIONAL GIFTS	A	0	ONCOLOGY	56.01	0	45.23
45.24	PROMOTIONAL GIFTS	A	-5,253	PHYSICAL THERAPY	66.00	0	45.24
45.25	PROMOTIONAL GIFTS	A	-385	RURAL HEALTH CLINIC	88.00	0	45.25
45.26	PROMOTIONAL GIFTS	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.26
45.27	PROMOTIONAL GIFTS	A	-892	CLINIC	90.00	0	45.27
45.28	PROMOTIONAL GIFTS	A	-255	ELECTROCARDIOLOGY	69.00	0	45.28
45.29	MAJ WOUND CARE ADVERTISING	A	0	CLINIC	90.00	0	45.29
45.30	MAJ BEE UNIQUE BOUT ADVERTISING	A	-95	ONCOLOGY	56.01	0	45.30
45.31	MAJ MHP FIM ADVERTISING	A	0	RURAL HEALTH CLINIC III	88.02	0	45.31

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/27/2022 10:37 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
45.32	MAJ COMMUNITY OUTRE ADVERTISING	A	-1,500	ADMINISTRATIVE & GENERAL	5.00	0	45.32
45.33	MAJ MARKETING ADVERTISING	A	-19,747	ADMINISTRATIVE & GENERAL	5.00	0	45.33
45.34	MAJ HUMAN RESOURCES ADVERTISING	B	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.34
45.35	MAJ ADMINISTRATION ADVERTISING	A	-1,450	ADMINISTRATIVE & GENERAL	5.00	0	45.35
45.36	MAJ REHABILATION SE ADVERTISING-SPOR	A	0	PHYSICAL THERAPY	66.00	0	45.36
45.37	MAJ HUMAN RESOURCES ADVERTISING	A	0	RURAL HEALTH CLINIC II	88.01	0	45.37
45.38	COMMUNITY OUTREACH	A	-367,142	ADMINISTRATIVE & GENERAL	5.00	0	45.38
45.39	HAF EXPENSE	A	-4,928,475	ADMINISTRATIVE & GENERAL	5.00	0	45.39
45.40	NON-ALLOWABLE RHC	A	-32,746	RURAL HEALTH CLINIC II	88.01	0	45.40
45.41	LOBBYING % OF DUES	A	-7,246	ADMINISTRATIVE & GENERAL	5.00	0	45.41
45.42	MISC. PURCHASED SERVICES	A	-6,550,222	ADMINISTRATIVE & GENERAL	5.00	0	45.42
45.43	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.43
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-20,178,621				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0097	Period: From 01/01/2021 To 12/31/2021	Worksheet A-8-1 Date/Time Prepared: 5/27/2022 10:37 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	88.00	RURAL HEALTH CLINIC	MHP PEDS RHC	1,560,127	789,907	1.00
2.00	88.01	RURAL HEALTH CLINIC II	MHP OBGYN RHC	818,482	739,579	2.00
3.00	88.02	RURAL HEALTH CLINIC III	MHP FIM RHC	5,145,443	3,132,386	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,524,052	4,661,872	5.00

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

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

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

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

6.00	B		0.00	MMG	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0097	Period: From 01/01/2021 To 12/31/2021	Worksheet A-8-1 Date/Time Prepared: 5/27/2022 10:37 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	770,220	0		1.00
2.00	78,903	0		2.00
3.00	2,013,057	0		3.00
4.00	0	0		4.00
5.00	2,862,180			5.00

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

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

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

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

6.00	PHYSICIAN GROUP		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 5/27/2022 10:37 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	34,272	0	34,272	179,000	290	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	1,477	1,074	403	179,000	4	2.00
3.00	13.00	NURSING ADMINISTRATION	627	627	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	3,525,676	2,831,593	694,083	239,400	2,968	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	1,038,704	1,038,704	0	0	0	6.00
7.00	56.01	ONCOLOGY	227,356	202,356	25,000	271,900	150	7.00
8.00	57.00	CT SCAN	56,124	56,124	0	0	0	8.00
9.00	60.00	LABORATORY	165,534	30,065	135,469	260,300	169	9.00
10.00	69.00	ELECTROCARDIOLOGY	21,721	21,721	0	0	0	10.00
11.00	90.00	CLINIC	653,861	558,437	95,424	179,000	418	11.00
12.00	91.00	EMERGENCY	847,500	785,000	62,500	179,000	504	12.00
200.00			6,572,852	5,525,701	1,047,151		4,503	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	24,957	1,248	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	344	17	0	0	0	2.00
3.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	341,605	17,080	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	56.01	ONCOLOGY	19,608	980	0	0	0	7.00
8.00	57.00	CT SCAN	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	21,149	1,057	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	90.00	CLINIC	35,972	1,799	0	0	0	11.00
12.00	91.00	EMERGENCY	43,373	2,169	0	0	0	12.00
200.00			487,008	24,350	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	24,957	9,315	9,315		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	344	59	1,133		2.00
3.00	13.00	NURSING ADMINISTRATION	0	0	0	627		3.00
4.00	50.00	OPERATING ROOM	0	0	0	0		4.00
5.00	53.00	ANESTHESIOLOGY	0	341,605	352,478	3,184,071		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,038,704		6.00
7.00	56.01	ONCOLOGY	0	19,608	5,392	207,748		7.00
8.00	57.00	CT SCAN	0	0	0	56,124		8.00
9.00	60.00	LABORATORY	0	21,149	114,320	144,385		9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	21,721		10.00
11.00	90.00	CLINIC	0	35,972	59,452	617,889		11.00
12.00	91.00	EMERGENCY	0	43,373	19,127	804,127		12.00
200.00			0	487,008	560,143	6,085,844		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/27/2022 10:37 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	13,196,745	13,196,745				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,225,543	53,228	12,278,771			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,799,236	1,108,351	1,972,204	20,879,791	20,879,791	5.00
7.00	00700	OPERATION OF PLANT	3,287,605	705,714	273,928	4,267,247	757,812	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	294,142	60,035	28,085	382,262	67,885	8.00
9.00	00900	HOUSEKEEPING	2,849,843	137,767	363,019	3,350,629	595,032	9.00
10.00	01000	DIETARY	641,640	103,416	59,315	804,371	142,847	10.00
11.00	01100	CAFETERIA	1,194,209	229,883	128,570	1,552,662	275,734	11.00
13.00	01300	NURSING ADMINISTRATION	1,485,408	118,300	200,994	1,804,702	320,493	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,758	146,888	0	150,646	26,753	14.00
15.00	01500	PHARMACY	13,342,454	122,066	263,526	13,728,046	2,437,936	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,861,733	101,419	299,455	2,262,607	401,812	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,165,539	1,150,370	1,413,563	10,729,472	1,905,425	30.00
31.00	03100	INTENSIVE CARE UNIT	2,978,909	226,435	511,338	3,716,682	660,038	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,488,874	1,270,166	566,278	7,325,318	1,300,889	50.00
53.00	05300	ANESTHESIOLOGY	89,185	22,734	143,607	255,526	45,378	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,682,621	404,452	674,201	5,761,274	1,023,133	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	2,187,202	904,559	298,384	3,390,145	602,049	56.01
57.00	05700	CT SCAN	763,382	67,204	80,595	911,181	161,815	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	791,723	68,021	95,354	955,098	169,614	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	7,276,420	261,103	474,241	8,011,764	1,422,793	60.00
65.00	06500	RESPIRATORY THERAPY	1,646,813	209,010	288,302	2,144,125	380,771	65.00
65.01	06501	SLEEP LAB	578,963	0	91,517	670,480	119,069	65.01
66.00	06600	PHYSICAL THERAPY	2,106,714	535,775	409,311	3,051,800	541,963	66.00
69.00	06900	ELECTROCARDIOLOGY	2,323,895	172,571	152,936	2,649,402	470,502	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,995,353	0	20,606	2,015,959	358,010	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,530,894	332,165	280,046	4,143,105	735,766	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,792,053	196,259	127,456	2,115,768	375,735	88.01
88.02	08802	RURAL HEALTH CLINIC III	12,193,898	1,095,009	1,120,216	14,409,123	2,558,884	88.02
90.00	09000	CLINIC	1,810,236	439,574	300,202	2,550,012	452,852	90.00
91.00	09100	EMERGENCY	3,828,947	594,040	629,198	5,052,185	897,207	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,681,702	333,753	281,600	2,297,055	407,929	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	134,095,639	11,170,267	11,548,047	131,338,437	19,616,126	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34,079	0	34,079	6,052	190.00
190.01	19001	UROLOGY	47,627	0	2,635	50,262	8,926	190.01
190.05	19005	MARKETING	269,175	28,134	23,728	321,037	57,012	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	136,769	499,291	13,325	649,385	115,323	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	36,817	433,402	2,441	472,660	83,939	190.09
190.11	19011	MHP ADMIN BUILDING	72,839	13,613	9,051	95,503	16,960	190.11
190.16	19016	RENOVO	102,284	495,298	8,806	606,388	107,687	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	3,486,075	10,165	634,988	4,131,228	733,657	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	0	113,444	0	113,444	20,146	192.02
194.00	07950	UNAVIE	206,927	399,052	35,750	641,729	113,963	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	138,454,152	13,196,745	12,278,771	138,454,152	20,879,791	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/27/2022 10:37 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	5,025,059					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,628	476,775				8.00
9.00	00900	HOUSEKEEPING	61,105	0	4,006,766			9.00
10.00	01000	DIETARY	45,869	0	37,224	1,030,311		10.00
11.00	01100	CAFETERIA	101,962	0	82,745	0	2,013,103	11.00
13.00	01300	NURSING ADMINISTRATION	52,471	0	42,581	0	28,396	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	65,150	0	52,871	0	0	14.00
15.00	01500	PHARMACY	54,141	0	43,937	0	43,874	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,983	0	36,505	0	93,209	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	510,235	185,036	414,068	819,221	292,169	30.00
31.00	03100	INTENSIVE CARE UNIT	100,433	0	81,504	211,090	101,912	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	563,370	47,091	457,187	0	130,885	50.00
53.00	05300	ANESTHESIOLOGY	10,084	0	8,183	0	29,238	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	179,390	83,697	145,580	0	137,999	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	401,208	29,929	325,590	0	62,907	56.01
57.00	05700	CT SCAN	29,808	0	24,190	0	14,203	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	30,170	0	24,484	0	18,443	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	115,810	0	93,982	0	134,664	60.00
65.00	06500	RESPIRATORY THERAPY	92,704	11,899	75,232	0	54,469	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	237,637	15,139	192,849	0	79,759	66.00
69.00	06900	ELECTROCARDIOLOGY	76,542	0	62,116	0	29,304	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	8,353	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	147,328	0	119,561	0	84,102	88.00
88.01	08801	RURAL HEALTH CLINIC II	87,048	0	70,642	0	40,691	88.01
88.02	08802	RURAL HEALTH CLINIC III	485,680	0	394,142	0	309,670	88.02
90.00	09000	CLINIC	194,968	0	158,222	0	54,469	90.00
91.00	09100	EMERGENCY	263,480	103,984	213,821	0	137,096	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	148,033	0	120,132	0	53,994	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,126,237	476,775	3,277,348	1,030,311	1,939,806	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,115	0	12,266	0	0	190.00
190.01	19001	UROLOGY	0	0	0	0	0	190.01
190.05	19005	MARKETING	12,479	0	10,127	0	5,294	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	221,455	0	179,717	0	5,817	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	192,231	0	156,000	0	1,273	190.09
190.11	19011	MHP ADMIN BUILDING	6,038	0	4,900	0	3,471	190.11
190.16	19016	RENOVO	219,684	0	178,279	0	2,960	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	54,482	192.00
192.01	19201	HOSPITALIST	4,508	0	3,659	0	0	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	50,317	0	40,834	0	0	192.02
194.00	07950	UNAVIE	176,995	0	143,636	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,025,059	476,775	4,006,766	1,030,311	2,013,103	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/27/2022 10:37 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		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
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	2,248,643					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	295,420				14.00
15.00	01500	PHARMACY	0	0	16,307,934			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	2,839,116		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	441,209	0	0	104,821	15,401,656	30.00
31.00	03100	INTENSIVE CARE UNIT	153,899	0	0	41,063	5,066,621	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	197,651	162,481	0	489,321	10,674,193	50.00
53.00	05300	ANESTHESIOLOGY	44,153	0	0	3,787	396,349	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	194,079	7,525,152	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	94,996	0	0	137,237	5,044,061	56.01
57.00	05700	CT SCAN	0	0	0	193,656	1,334,853	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	63,866	1,261,675	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	316,250	10,095,263	60.00
65.00	06500	RESPIRATORY THERAPY	82,254	0	0	75,092	2,916,546	65.00
65.01	06501	SLEEP LAB	29,761	0	0	19,608	838,918	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	54,691	4,173,838	66.00
69.00	06900	ELECTROCARDIOLOGY	44,253	0	0	103,299	3,435,418	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	132,939	0	62,308	2,577,569	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	16,307,934	329,877	16,637,811	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	127,003	0	0	27,088	5,383,953	88.00
88.01	08801	RURAL HEALTH CLINIC II	61,447	0	0	16,824	2,768,155	88.01
88.02	08802	RURAL HEALTH CLINIC III	467,636	0	0	98,787	18,723,922	88.02
90.00	09000	CLINIC	82,254	0	0	37,040	3,529,817	90.00
91.00	09100	EMERGENCY	207,031	0	0	411,757	7,286,561	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	81,537	0	0	58,665	3,167,345	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,115,084	295,420	16,307,934	2,839,116	128,239,676	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	67,512	190.00
190.01	19001	UROLOGY	0	0	0	0	59,188	190.01
190.05	19005	MARKETING	0	0	0	0	405,949	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	8,784	0	0	0	1,180,481	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	1,923	0	0	0	908,026	190.09
190.11	19011	MHP ADMIN BUILDING	0	0	0	0	126,872	190.11
190.16	19016	RENOVO	4,470	0	0	0	1,119,468	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	82,274	0	0	0	136,756	192.00
192.01	19201	HOSPITALIST	0	0	0	0	4,873,052	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	0	0	0	0	224,741	192.02
194.00	07950	UNAVIE	36,108	0	0	0	1,112,431	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,248,643	295,420	16,307,934	2,839,116	138,454,152	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/27/2022 10:37 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	15,401,656		30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,066,621		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	10,674,193		50.00
53.00	05300	ANESTHESIOLOGY	0	396,349		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,525,152		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	05601	ONCOLOGY	0	5,044,061		56.01
57.00	05700	CT SCAN	0	1,334,853		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,261,675		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	10,095,263		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,916,546		65.00
65.01	06501	SLEEP LAB	0	838,918		65.01
66.00	06600	PHYSICAL THERAPY	0	4,173,838		66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,435,418		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,577,569		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,637,811		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	5,383,953		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,768,155		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	18,723,922		88.02
90.00	09000	CLINIC	0	3,529,817		90.00
91.00	09100	EMERGENCY	0	7,286,561		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	3,167,345		92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	128,239,676		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	67,512		190.00
190.01	19001	UROLOGY	0	59,188		190.01
190.05	19005	MARKETING	0	405,949		190.05
190.07	19007	I-74 CAMPUS	0	0		190.07
190.08	19008	RAMPART	0	1,180,481		190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	908,026		190.09
190.11	19011	MHP ADMIN BUILDING	0	126,872		190.11
190.16	19016	RENOVO	0	1,119,468		190.16
190.17	19017	IMA	0	0		190.17
190.18	19018	MD SOLUTIONS	0	0		190.18
190.19	19019	MHCD	0	0		190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	136,756		192.00
192.01	19201	HOSPITALIST	0	4,873,052		192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	0	224,741		192.02
194.00	07950	UNAVIE	0	1,112,431		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	138,454,152		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/27/2022 10:37 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			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	53,228	53,228	53,228		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,108,351	1,108,351	8,541	1,116,892	5.00
7.00	00700	OPERATION OF PLANT	0	705,714	705,714	1,188	40,535	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	60,035	60,035	122	3,631	8.00
9.00	00900	HOUSEKEEPING	0	137,767	137,767	1,574	31,828	9.00
10.00	01000	DIETARY	0	103,416	103,416	257	7,641	10.00
11.00	01100	CAFETERIA	0	229,883	229,883	557	14,749	11.00
13.00	01300	NURSING ADMINISTRATION	0	118,300	118,300	872	17,143	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	146,888	146,888	0	1,431	14.00
15.00	01500	PHARMACY	0	122,066	122,066	1,143	130,403	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	101,419	101,419	1,298	21,493	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,150,370	1,150,370	6,129	101,919	30.00
31.00	03100	INTENSIVE CARE UNIT	0	226,435	226,435	2,217	35,305	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,270,166	1,270,166	2,455	69,583	50.00
53.00	05300	ANESTHESIOLOGY	0	22,734	22,734	623	2,427	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	404,452	404,452	2,923	54,726	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0	904,559	904,559	1,294	32,203	56.01
57.00	05700	CT SCAN	0	67,204	67,204	349	8,655	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	68,021	68,021	413	9,072	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	261,103	261,103	2,056	76,104	60.00
65.00	06500	RESPIRATORY THERAPY	0	209,010	209,010	1,250	20,367	65.00
65.01	06501	SLEEP LAB	0	0	0	397	6,369	65.01
66.00	06600	PHYSICAL THERAPY	0	535,775	535,775	1,775	28,989	66.00
69.00	06900	ELECTROCARDIOLOGY	0	172,571	172,571	663	25,167	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	89	19,150	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	332,165	332,165	1,214	39,355	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	196,259	196,259	553	20,098	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,095,009	1,095,009	4,857	136,921	88.02
90.00	09000	CLINIC	0	439,574	439,574	1,302	24,223	90.00
91.00	09100	EMERGENCY	0	594,040	594,040	2,728	47,991	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	333,753	333,753	1,221	21,820	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	11,170,267	11,170,267	50,060	1,049,298	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34,079	34,079	0	324	190.00
190.01	19001	UROLOGY	0	0	0	11	477	190.01
190.05	19005	MARKETING	0	28,134	28,134	103	3,050	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	0	499,291	499,291	58	6,169	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	433,402	433,402	11	4,490	190.09
190.11	19011	MHP ADMIN BUILDING	0	13,613	13,613	39	907	190.11
190.16	19016	RENOVO	0	495,298	495,298	38	5,760	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	0	10,165	10,165	2,753	39,243	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	0	113,444	113,444	0	1,078	192.02
194.00	07950	UNAVIE	0	399,052	399,052	155	6,096	194.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	13,196,745	13,196,745	53,228	1,116,892	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/27/2022 10:37 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	747,437					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,961	67,749				8.00
9.00	00900	HOUSEKEEPING	9,089	0	180,258			9.00
10.00	01000	DIETARY	6,823	0	1,675	119,812		10.00
11.00	01100	CAFETERIA	15,166	0	3,723	0	264,078	11.00
13.00	01300	NURSING ADMINISTRATION	7,805	0	1,916	0	3,725	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,691	0	2,379	0	0	14.00
15.00	01500	PHARMACY	8,053	0	1,977	0	5,755	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,691	0	1,642	0	12,227	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	75,893	26,293	18,628	95,265	38,327	30.00
31.00	03100	INTENSIVE CARE UNIT	14,939	0	3,667	24,547	13,369	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	83,792	6,692	20,568	0	17,169	50.00
53.00	05300	ANESTHESIOLOGY	1,500	0	368	0	3,835	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,683	11,893	6,549	0	18,103	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	59,676	4,253	14,648	0	8,252	56.01
57.00	05700	CT SCAN	4,434	0	1,088	0	1,863	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,488	0	1,101	0	2,419	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	17,226	0	4,228	0	17,665	60.00
65.00	06500	RESPIRATORY THERAPY	13,789	1,691	3,385	0	7,145	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	35,347	2,151	8,676	0	10,463	66.00
69.00	06900	ELECTROCARDIOLOGY	11,385	0	2,794	0	3,844	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,096	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	21,914	0	5,379	0	11,032	88.00
88.01	08801	RURAL HEALTH CLINIC II	12,948	0	3,178	0	5,338	88.01
88.02	08802	RURAL HEALTH CLINIC III	72,241	0	17,732	0	40,625	88.02
90.00	09000	CLINIC	29,000	0	7,118	0	7,145	90.00
91.00	09100	EMERGENCY	39,191	14,776	9,619	0	17,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	22,019	0	5,405	0	7,083	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	613,744	67,749	147,443	119,812	254,464	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,248	0	552	0	0	190.00
190.01	19001	UROLOGY	0	0	0	0	0	190.01
190.05	19005	MARKETING	1,856	0	456	0	694	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	32,940	0	8,085	0	763	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	28,593	0	7,018	0	167	190.09
190.11	19011	MHP ADMIN BUILDING	898	0	220	0	455	190.11
190.16	19016	RENOVO	32,676	0	8,020	0	388	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	7,147	192.00
192.01	19201	HOSPITALIST	671	0	165	0	0	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	7,484	0	1,837	0	0	192.02
194.00	07950	UNAVIE	26,327	0	6,462	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	747,437	67,749	180,258	119,812	264,078	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/27/2022 10:37 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		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
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	149,761					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	160,389				14.00
15.00	01500	PHARMACY	0	0	269,397			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	144,770		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,385	0	0	5,348	1,547,557	30.00
31.00	03100	INTENSIVE CARE UNIT	10,250	0	0	2,095	332,824	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,164	88,214	0	24,880	1,596,683	50.00
53.00	05300	ANESTHESIOLOGY	2,941	0	0	193	34,621	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,902	535,231	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	6,327	0	0	7,002	1,038,214	56.01
57.00	05700	CT SCAN	0	0	0	9,881	93,474	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,259	88,773	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	16,136	394,518	60.00
65.00	06500	RESPIRATORY THERAPY	5,478	0	0	3,831	265,946	65.00
65.01	06501	SLEEP LAB	1,982	0	0	1,000	9,748	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	2,790	625,966	66.00
69.00	06900	ELECTROCARDIOLOGY	2,947	0	0	5,271	224,642	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	72,175	0	3,179	95,689	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	269,397	16,831	286,228	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,458	0	0	1,382	420,899	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,092	0	0	858	243,324	88.01
88.02	08802	RURAL HEALTH CLINIC III	31,146	0	0	5,040	1,403,571	88.02
90.00	09000	CLINIC	5,478	0	0	1,890	515,730	90.00
91.00	09100	EMERGENCY	13,788	0	0	21,009	761,126	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	5,430	0	0	2,993	399,724	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	140,866	160,389	269,397	144,770	10,914,488	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	37,203	190.00
190.01	19001	UROLOGY	0	0	0	0	488	190.01
190.05	19005	MARKETING	0	0	0	0	34,293	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	585	0	0	0	547,891	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	128	0	0	0	473,809	190.09
190.11	19011	MHP ADMIN BUILDING	0	0	0	0	16,132	190.11
190.16	19016	RENOVO	298	0	0	0	542,478	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,479	0	0	0	12,626	192.00
192.01	19201	HOSPITALIST	0	0	0	0	52,997	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	0	0	0	0	123,843	192.02
194.00	07950	UNAVIE	2,405	0	0	0	440,497	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	149,761	160,389	269,397	144,770	13,196,745	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/27/2022 10:37 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,547,557		30.00
31.00	03100	INTENSIVE CARE UNIT	0	332,824		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,596,683		50.00
53.00	05300	ANESTHESIOLOGY	0	34,621		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	535,231		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	05601	ONCOLOGY	0	1,038,214		56.01
57.00	05700	CT SCAN	0	93,474		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	88,773		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	394,518		60.00
65.00	06500	RESPIRATORY THERAPY	0	265,946		65.00
65.01	06501	SLEEP LAB	0	9,748		65.01
66.00	06600	PHYSICAL THERAPY	0	625,966		66.00
69.00	06900	ELECTROCARDIOLOGY	0	224,642		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	95,689		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	286,228		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	420,899		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	243,324		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,403,571		88.02
90.00	09000	CLINIC	0	515,730		90.00
91.00	09100	EMERGENCY	0	761,126		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	399,724		92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	10,914,488		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	37,203		190.00
190.01	19001	UROLOGY	0	488		190.01
190.05	19005	MARKETING	0	34,293		190.05
190.07	19007	I-74 CAMPUS	0	0		190.07
190.08	19008	RAMPART	0	547,891		190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	473,809		190.09
190.11	19011	MHP ADMIN BUILDING	0	16,132		190.11
190.16	19016	RENOVO	0	542,478		190.16
190.17	19017	IMA	0	0		190.17
190.18	19018	MD SOLUTIONS	0	0		190.18
190.19	19019	MHCD	0	0		190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,626		192.00
192.01	19201	HOSPITALIST	0	52,997		192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	0	123,843		192.02
194.00	07950	UNAVIE	0	440,497		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	13,196,745		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 10:37 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	290,820					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,173	58,315,384				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,425	9,366,544	-20,879,791	117,574,361		5.00
7.00	00700	OPERATION OF PLANT	15,552	1,300,964	0	4,267,247	249,670	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,323	133,386	0	382,262	1,323	8.00
9.00	00900	HOUSEKEEPING	3,036	1,724,081	0	3,350,629	3,036	9.00
10.00	01000	DIETARY	2,279	281,706	0	804,371	2,279	10.00
11.00	01100	CAFETERIA	5,066	610,617	0	1,552,662	5,066	11.00
13.00	01300	NURSING ADMINISTRATION	2,607	954,580	0	1,804,702	2,607	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,237	0	0	150,646	3,237	14.00
15.00	01500	PHARMACY	2,690	1,251,561	0	13,728,046	2,690	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,235	1,422,195	0	2,262,607	2,235	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,351	6,713,415	0	10,729,472	25,351	30.00
31.00	03100	INTENSIVE CARE UNIT	4,990	2,428,488	0	3,716,682	4,990	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,991	2,689,417	0	7,325,318	27,991	50.00
53.00	05300	ANESTHESIOLOGY	501	682,030	0	255,526	501	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,913	3,201,972	0	5,761,274	8,913	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	19,934	1,417,113	0	3,390,145	19,934	56.01
57.00	05700	CT SCAN	1,481	382,769	0	911,181	1,481	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,499	452,863	0	955,098	1,499	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	5,754	2,252,305	0	8,011,764	5,754	60.00
65.00	06500	RESPIRATORY THERAPY	4,606	1,369,230	0	2,144,125	4,606	65.00
65.01	06501	SLEEP LAB	0	434,642	0	670,480	0	65.01
66.00	06600	PHYSICAL THERAPY	11,807	1,943,937	0	3,051,800	11,807	66.00
69.00	06900	ELECTROCARDIOLOGY	3,803	726,335	0	2,649,402	3,803	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	97,864	0	2,015,959	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,320	1,330,017	0	4,143,105	7,320	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,325	605,323	0	2,115,768	4,325	88.01
88.02	08802	RURAL HEALTH CLINIC III	24,131	5,320,225	0	14,409,123	24,131	88.02
90.00	09000	CLINIC	9,687	1,425,743	0	2,550,012	9,687	90.00
91.00	09100	EMERGENCY	13,091	2,988,243	0	5,052,185	13,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	7,355	1,337,401	0	2,297,055	7,355	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	246,162	54,844,966	-20,879,791	110,458,646	205,012	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	751	0	0	34,079	751	190.00
190.01	19001	UROLOGY	0	12,515	0	50,262	0	190.01
190.05	19005	MARKETING	620	112,691	0	321,037	620	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	11,003	63,284	0	649,385	11,003	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	9,551	11,592	0	472,660	9,551	190.09
190.11	19011	MHP ADMIN BUILDING	300	42,986	0	95,503	300	190.11
190.16	19016	RENOVO	10,915	41,822	0	606,388	10,915	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	224	3,015,741	0	4,131,228	224	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	2,500	0	0	113,444	2,500	192.02
194.00	07950	UNAVIE	8,794	169,787	0	641,729	8,794	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	13,196,745	12,278,771		20,879,791	5,025,059	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	45.377708	0.210558		0.177588	20.126803	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 10:37 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
204.00		Cost to be allocated (per Wkst. B, Part II)		53,228		1,116,892	747,437	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000913		0.009499	2.993700	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: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 10:37 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	
			8.00	9.00	10.00	11.00	13.00	
		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
8.00	00800	LAUNDRY & LINEN SERVICE	412,534					8.00
9.00	00900	HOUSEKEEPING	0	245,311				9.00
10.00	01000	DIETARY	0	2,279	11,270			10.00
11.00	01100	CAFETERIA	0	5,066	0	1,212,695		11.00
13.00	01300	NURSING ADMINISTRATION	0	2,607	0	17,106	897,008	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,237	0	0	0	14.00
15.00	01500	PHARMACY	0	2,690	0	26,430	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,235	0	56,149	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	160,104	25,351	8,961	176,003	176,003	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,990	2,309	61,392	61,392	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,746	27,991	0	78,845	78,845	50.00
53.00	05300	ANESTHESIOLOGY	0	501	0	17,613	17,613	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,420	8,913	0	83,131	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	25,896	19,934	0	37,895	37,895	56.01
57.00	05700	CT SCAN	0	1,481	0	8,556	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,499	0	11,110	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	5,754	0	81,122	0	60.00
65.00	06500	RESPIRATORY THERAPY	10,296	4,606	0	32,812	32,812	65.00
65.01	06501	SLEEP LAB	0	0	0	0	11,872	65.01
66.00	06600	PHYSICAL THERAPY	13,099	11,807	0	48,047	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,803	0	17,653	17,653	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	5,032	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,320	0	50,663	50,663	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,325	0	24,512	24,512	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	24,131	0	186,545	186,545	88.02
90.00	09000	CLINIC	0	9,687	0	32,812	32,812	90.00
91.00	09100	EMERGENCY	89,973	13,091	0	82,587	82,587	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	7,355	0	32,526	32,526	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	412,534	200,653	11,270	1,168,541	843,730	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	751	0	0	0	190.00
190.01	19001	UROLOGY	0	0	0	0	0	190.01
190.05	19005	MARKETING	0	620	0	3,189	0	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	0	11,003	0	3,504	3,504	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	9,551	0	767	767	190.09
190.11	19011	MHP ADMIN BUILDING	0	300	0	2,091	0	190.11
190.16	19016	RENOVO	0	10,915	0	1,783	1,783	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	32,820	32,820	192.00
192.01	19201	HOSPITALIST	0	224	0	0	0	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	0	2,500	0	0	0	192.02
194.00	07950	UNAVIE	0	8,794	0	0	14,404	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	476,775	4,006,766	1,030,311	2,013,103	2,248,643	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.155723	16.333414	91.420674	1.660024	2.506826	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	67,749	180,258	119,812	264,078	149,761	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.164226	0.734814	10.631056	0.217761	0.166956	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 10:37 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	
			8.00	9.00	10.00	11.00	13.00	
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: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 10:37 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS TO PATIENTS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			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					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100				14.00
15.00	01500	PHARMACY	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	487,696,818		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	18,007,457		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	7,054,204		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	55	0	84,021,079		50.00
53.00	05300	ANESTHESIOLOGY	0	0	650,652		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	33,341,097		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
56.01	05601	ONCOLOGY	0	0	23,576,183		56.01
57.00	05700	CT SCAN	0	0	33,268,561		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	10,971,637		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	54,329,158		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	12,900,171		65.00
65.01	06501	SLEEP LAB	0	0	3,368,561		65.01
66.00	06600	PHYSICAL THERAPY	0	0	9,395,487		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	17,745,993		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	45	0	10,703,976		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	56,670,078		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	4,653,569		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	2,890,273		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	16,970,856		88.02
90.00	09000	CLINIC	0	0	6,363,156		90.00
91.00	09100	EMERGENCY	0	0	70,736,427		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	10,078,243		92.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	487,696,818		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	UROLOGY	0	0	0		190.01
190.05	19005	MARKETING	0	0	0		190.05
190.07	19007	I-74 CAMPUS	0	0	0		190.07
190.08	19008	RAMPART	0	0	0		190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	0	0		190.09
190.11	19011	MHP ADMIN BUILDING	0	0	0		190.11
190.16	19016	RENOVO	0	0	0		190.16
190.17	19017	IMA	0	0	0		190.17
190.18	19018	MD SOLUTIONS	0	0	0		190.18
190.19	19019	MHCD	0	0	0		190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	HOSPITALIST	0	0	0		192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	0	0	0		192.02
194.00	07950	UNAVIE	0	0	0		194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	295,420	16,307,934	2,839,116		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2,954.200000	163,079.340000	0.005821		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	160,389	269,397	144,770		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 10:37 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS TO PATIENTS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			14.00	15.00	16.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	1,603.890000	2,693.970000	0.000297		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: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,401,656		15,401,656	0	15,401,656	30.00
31.00	03100	INTENSIVE CARE UNIT	5,066,621		5,066,621	0	5,066,621	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,674,193		10,674,193	0	10,674,193	50.00
53.00	05300	ANESTHESIOLOGY	396,349		396,349	352,478	748,827	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,525,152		7,525,152	0	7,525,152	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
56.01	05601	ONCOLOGY	5,044,061		5,044,061	5,392	5,049,453	56.01
57.00	05700	CT SCAN	1,334,853		1,334,853	0	1,334,853	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,261,675		1,261,675	0	1,261,675	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	10,095,263		10,095,263	114,320	10,209,583	60.00
65.00	06500	RESPIRATORY THERAPY	2,916,546	0	2,916,546	0	2,916,546	65.00
65.01	06501	SLEEP LAB	838,918	0	838,918	0	838,918	65.01
66.00	06600	PHYSICAL THERAPY	4,173,838	0	4,173,838	0	4,173,838	66.00
69.00	06900	ELECTROCARDIOLOGY	3,435,418		3,435,418	0	3,435,418	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,577,569		2,577,569	0	2,577,569	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,637,811		16,637,811	0	16,637,811	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,383,953		5,383,953	0	5,383,953	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,768,155		2,768,155	0	2,768,155	88.01
88.02	08802	RURAL HEALTH CLINIC III	18,723,922		18,723,922	0	18,723,922	88.02
90.00	09000	CLINIC	3,529,817		3,529,817	59,452	3,589,269	90.00
91.00	09100	EMERGENCY	7,286,561		7,286,561	19,127	7,305,688	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,341,546		1,341,546		1,341,546	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	3,167,345		3,167,345	0	3,167,345	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	129,581,222	0	129,581,222	550,769	130,131,991	200.00
201.00		Less Observation Beds	1,341,546		1,341,546		1,341,546	201.00
202.00		Total (see instructions)	128,239,676	0	128,239,676	550,769	128,790,445	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,545,708		16,545,708			30.00
31.00	03100	INTENSIVE CARE UNIT	7,054,204		7,054,204			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,948,518	71,072,561	84,021,079	0.127042	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	650,652	650,652	0.609157	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,117,182	30,223,915	33,341,097	0.225702	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
56.01	05601	ONCOLOGY	149,958	23,426,225	23,576,183	0.213947	0.000000	56.01
57.00	05700	CT SCAN	5,619,770	27,648,791	33,268,561	0.040124	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	822,287	10,149,350	10,971,637	0.114994	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	9,508,219	44,820,939	54,329,158	0.185817	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	11,319,961	1,580,210	12,900,171	0.226086	0.000000	65.00
65.01	06501	SLEEP LAB	0	3,368,561	3,368,561	0.249043	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,504,564	7,890,923	9,395,487	0.444239	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	2,486,630	15,259,363	17,745,993	0.193588	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,513,855	8,190,121	10,703,976	0.240805	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,665,010	39,005,068	56,670,078	0.293591	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,653,569	4,653,569			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,890,273	2,890,273			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	16,970,856	16,970,856			88.02
90.00	09000	CLINIC	34,370	6,328,786	6,363,156	0.554727	0.000000	90.00
91.00	09100	EMERGENCY	11,935,083	58,801,344	70,736,427	0.103010	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	10,651	1,451,098	1,461,749	0.917768	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,974,382	8,103,861	10,078,243	0.314276	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	105,210,352	382,486,466	487,696,818			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	105,210,352	382,486,466	487,696,818			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.127042		50.00
53.00	05300	ANESTHESIOLOGY	1.150887		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225702		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
56.01	05601	ONCOLOGY	0.214176		56.01
57.00	05700	CT SCAN	0.040124		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.114994		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.187921		60.00
65.00	06500	RESPIRATORY THERAPY	0.226086		65.00
65.01	06501	SLEEP LAB	0.249043		65.01
66.00	06600	PHYSICAL THERAPY	0.444239		66.00
69.00	06900	ELECTROCARDIOLOGY	0.193588		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.240805		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293591		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
90.00	09000	CLINIC	0.564071		90.00
91.00	09100	EMERGENCY	0.103280		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.917768		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.314276		92.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 10:37 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,401,656		15,401,656	0	15,401,656	30.00
31.00	03100	INTENSIVE CARE UNIT	5,066,621		5,066,621	0	5,066,621	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,674,193		10,674,193	0	10,674,193	50.00
53.00	05300	ANESTHESIOLOGY	396,349		396,349	352,478	748,827	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,525,152		7,525,152	0	7,525,152	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
56.01	05601	ONCOLOGY	5,044,061		5,044,061	5,392	5,049,453	56.01
57.00	05700	CT SCAN	1,334,853		1,334,853	0	1,334,853	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,261,675		1,261,675	0	1,261,675	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	10,095,263		10,095,263	114,320	10,209,583	60.00
65.00	06500	RESPIRATORY THERAPY	2,916,546	0	2,916,546	0	2,916,546	65.00
65.01	06501	SLEEP LAB	838,918	0	838,918	0	838,918	65.01
66.00	06600	PHYSICAL THERAPY	4,173,838	0	4,173,838	0	4,173,838	66.00
69.00	06900	ELECTROCARDIOLOGY	3,435,418		3,435,418	0	3,435,418	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,577,569		2,577,569	0	2,577,569	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,637,811		16,637,811	0	16,637,811	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,383,953		5,383,953	0	5,383,953	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,768,155		2,768,155	0	2,768,155	88.01
88.02	08802	RURAL HEALTH CLINIC III	18,723,922		18,723,922	0	18,723,922	88.02
90.00	09000	CLINIC	3,529,817		3,529,817	59,452	3,589,269	90.00
91.00	09100	EMERGENCY	7,286,561		7,286,561	19,127	7,305,688	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,341,546		1,341,546		1,341,546	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	3,167,345		3,167,345	0	3,167,345	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	129,581,222	0	129,581,222	550,769	130,131,991	200.00
201.00		Less Observation Beds	1,341,546		1,341,546		1,341,546	201.00
202.00		Total (see instructions)	128,239,676	0	128,239,676	550,769	128,790,445	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 10:37 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,545,708		16,545,708			30.00
31.00	03100	INTENSIVE CARE UNIT	7,054,204		7,054,204			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,948,518	71,072,561	84,021,079	0.127042	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	650,652	650,652	0.609157	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,117,182	30,223,915	33,341,097	0.225702	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
56.01	05601	ONCOLOGY	149,958	23,426,225	23,576,183	0.213947	0.000000	56.01
57.00	05700	CT SCAN	5,619,770	27,648,791	33,268,561	0.040124	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	822,287	10,149,350	10,971,637	0.114994	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	9,508,219	44,820,939	54,329,158	0.185817	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	11,319,961	1,580,210	12,900,171	0.226086	0.000000	65.00
65.01	06501	SLEEP LAB	0	3,368,561	3,368,561	0.249043	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,504,564	7,890,923	9,395,487	0.444239	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	2,486,630	15,259,363	17,745,993	0.193588	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,513,855	8,190,121	10,703,976	0.240805	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,665,010	39,005,068	56,670,078	0.293591	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,653,569	4,653,569	1.156951	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,890,273	2,890,273	0.957749	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	16,970,856	16,970,856	1.103299	0.000000	88.02
90.00	09000	CLINIC	34,370	6,328,786	6,363,156	0.554727	0.000000	90.00
91.00	09100	EMERGENCY	11,935,083	58,801,344	70,736,427	0.103010	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	10,651	1,451,098	1,461,749	0.917768	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,974,382	8,103,861	10,078,243	0.314276	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	105,210,352	382,486,466	487,696,818			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	105,210,352	382,486,466	487,696,818			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 10:37 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
56.01	05601	ONCOLOGY	0.000000		56.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	06501	SLEEP LAB	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part I Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,547,557	0	1,547,557	9,724	159.15	30.00
31.00	INTENSIVE CARE UNIT	332,824		332,824	2,309	144.14	31.00
200.00	Total (lines 30 through 199)	1,880,381		1,880,381	12,033		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	2,923	465,195	30.00
31.00	INTENSIVE CARE UNIT	532	76,682	31.00
200.00	Total (lines 30 through 199)	3,455	541,877	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,596,683	84,021,079	0.019003	3,079,310	58,516	50.00
53.00	05300	ANESTHESIOLOGY	34,621	650,652	0.053210	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	535,231	33,341,097	0.016053	1,051,028	16,872	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
56.01	05601	ONCOLOGY	1,038,214	23,576,183	0.044037	93,318	4,109	56.01
57.00	05700	CT SCAN	93,474	33,268,561	0.002810	1,917,854	5,389	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	88,773	10,971,637	0.008091	286,198	2,316	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	394,518	54,329,158	0.007262	3,027,642	21,987	60.00
65.00	06500	RESPIRATORY THERAPY	265,946	12,900,171	0.020616	3,346,618	68,994	65.00
65.01	06501	SLEEP LAB	9,748	3,368,561	0.002894	0	0	65.01
66.00	06600	PHYSICAL THERAPY	625,966	9,395,487	0.066624	593,041	39,511	66.00
69.00	06900	ELECTROCARDIOLOGY	224,642	17,745,993	0.012659	883,204	11,180	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	95,689	10,703,976	0.008940	993,600	8,883	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	286,228	56,670,078	0.005051	4,744,730	23,966	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	420,899	4,653,569	0.090446	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	243,324	2,890,273	0.084187	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,403,571	16,970,856	0.082705	0	0	88.02
90.00	09000	CLINIC	515,730	6,363,156	0.081049	16,090	1,304	90.00
91.00	09100	EMERGENCY	761,126	70,736,427	0.010760	3,826,613	41,174	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	134,799	1,461,749	0.092218	5,750	530	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	399,724	10,078,243	0.039662	479,211	19,006	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	9,168,906	464,096,906		24,344,207	323,737	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part III Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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	9,724	0.00	2,923	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,309	0.00	532	31.00
200.00		Total (lines 30 through 199)		0	12,033		3,455	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	84,021,079	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	650,652	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	33,341,097	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
56.01	05601	ONCOLOGY	0	0	0	23,576,183	0.000000	56.01
57.00	05700	CT SCAN	0	0	0	33,268,561	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	10,971,637	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	54,329,158	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,900,171	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	3,368,561	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	9,395,487	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,745,993	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	10,703,976	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	56,670,078	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,653,569	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,890,273	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	16,970,856	0.000000	88.02
90.00	09000	CLINIC	0	0	0	6,363,156	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	70,736,427	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,461,749	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	10,078,243	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	464,096,906		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	3,079,310	0	12,444,647	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	625,936	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,051,028	0	5,649,788	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0.000000	93,318	0	7,388,736	0	56.01
57.00	05700	CT SCAN	0.000000	1,917,854	0	5,582,697	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	286,198	0	2,382,122	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	3,027,642	0	3,364,782	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,346,618	0	424,042	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	533,986	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	593,041	0	215,068	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	883,204	0	3,868,585	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	993,600	0	1,809,207	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,744,730	0	13,049,386	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	16,090	0	1,859,131	0	90.00
91.00	09100	EMERGENCY	0.000000	3,826,613	0	8,160,747	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	5,750	0	597,072	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	479,211	0	1,214,939	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		24,344,207	0	69,170,871	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.127042	12,444,647	0	0	1,580,993	50.00
53.00	05300	ANESTHESIOLOGY	0.609157	625,936	0	0	381,293	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225702	5,649,788	0	0	1,275,168	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0.213947	7,388,736	0	0	1,580,798	56.01
57.00	05700	CT SCAN	0.040124	5,582,697	0	0	224,000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.114994	2,382,122	0	0	273,930	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.185817	3,364,782	0	0	625,234	60.00
65.00	06500	RESPIRATORY THERAPY	0.226086	424,042	0	0	95,870	65.00
65.01	06501	SLEEP LAB	0.249043	533,986	0	0	132,985	65.01
66.00	06600	PHYSICAL THERAPY	0.444239	215,068	0	0	95,542	66.00
69.00	06900	ELECTROCARDIOLOGY	0.193588	3,868,585	0	0	748,912	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.240805	1,809,207	0	0	435,666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293591	13,049,386	0	13,742	3,831,182	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
90.00	09000	CLINIC	0.554727	1,859,131	0	0	1,031,310	90.00
91.00	09100	EMERGENCY	0.103010	8,160,747	0	0	840,639	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.917768	597,072	0	0	547,974	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.314276	1,214,939	0	0	381,826	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		69,170,871	0	13,742	14,083,322	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		69,170,871	0	13,742	14,083,322	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	05601	ONCOLOGY	0	0		56.01
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	06501	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,035		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	4,035		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	4,035		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,724	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,724	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)	8,877	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)	2,923	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)	15,401,656	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)	15,401,656	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)	15,401,656	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,583.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,629,681	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)	4,629,681	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,066,621	2,309	2,194.29	532	1,167,362	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)	4,710,726	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	10,507,769	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)	541,877	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	323,737	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	865,614	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	9,642,155	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)	847	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,583.88	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,341,546	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,547,557	15,401,656	0.100480	1,341,546	134,799	90.00
91.00	Nursing Program cost	0	15,401,656	0.000000	1,341,546	0	91.00
92.00	Allied health cost	0	15,401,656	0.000000	1,341,546	0	92.00
93.00	All other Medical Education	0	15,401,656	0.000000	1,341,546	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 10:37 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,724	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,724	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)	8,877	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)	345	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)	15,401,656	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)	15,401,656	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)	15,401,656	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,583.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	546,439	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)	546,439	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 10:37 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,066,621	2,309	2,194.29	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	390,061	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	936,500	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)	847	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,583.88	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,341,546	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 10:37 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,547,557	15,401,656	0.100480	1,341,546	134,799	90.00
91.00	Nursing Program cost	0	15,401,656	0.000000	1,341,546	0	91.00
92.00	Allied health cost	0	15,401,656	0.000000	1,341,546	0	92.00
93.00	All other Medical Education	0	15,401,656	0.000000	1,341,546	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,234,958		30.00
31.00	03100	INTENSIVE CARE UNIT		1,974,972		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.127042	3,079,310	391,202	50.00
53.00	05300	ANESTHESIOLOGY	1.150887	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225702	1,051,028	237,219	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
56.01	05601	ONCOLOGY	0.214176	93,318	19,986	56.01
57.00	05700	CT SCAN	0.040124	1,917,854	76,952	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.114994	286,198	32,911	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.187921	3,027,642	568,958	60.00
65.00	06500	RESPIRATORY THERAPY	0.226086	3,346,618	756,623	65.00
65.01	06501	SLEEP LAB	0.249043	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.444239	593,041	263,452	66.00
69.00	06900	ELECTROCARDIOLOGY	0.193588	883,204	170,978	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.240805	993,600	239,264	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293591	4,744,730	1,393,010	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	0.564071	16,090	9,076	90.00
91.00	09100	EMERGENCY	0.103280	3,826,613	395,213	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.917768	5,750	5,277	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.314276	479,211	150,605	92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		24,344,207	4,710,726	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		24,344,207		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/27/2022 10:37 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		445,550		30.00
31.00	03100	INTENSIVE CARE UNIT		341,769		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.127042	454,583	57,751	50.00
53.00	05300	ANESTHESIOLOGY	0.609157	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225702	78,600	17,740	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
56.01	05601	ONCOLOGY	0.213947	328	70	56.01
57.00	05700	CT SCAN	0.040124	128,420	5,153	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.114994	128	15	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.185817	243,581	45,261	60.00
65.00	06500	RESPIRATORY THERAPY	0.226086	332,248	75,117	65.00
65.01	06501	SLEEP LAB	0.249043	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.444239	15,689	6,970	66.00
69.00	06900	ELECTROCARDIOLOGY	0.193588	68,589	13,278	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.240805	45,339	10,918	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293591	382,865	112,406	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.156951	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.957749	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.103299	0	0	88.02
90.00	09000	CLINIC	0.554727	641	356	90.00
91.00	09100	EMERGENCY	0.103010	270,338	27,848	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.917768	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.314276	54,660	17,178	92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,076,009	390,061	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,076,009		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0097	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/27/2022 10:37 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5,971,472	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,918,310	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	30,827	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	30,410	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	43.67	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.06	30.00
31.00	Percentage of Medicaid patient days (see instructions)	24.62	31.00
32.00	Sum of lines 30 and 31	27.68	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	236,693	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0097	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/27/2022 10:37 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,160,779	868,613	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	868,199	218,938	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,087,137		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	9,274,849		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	9,274,849	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	595,371	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	23,523	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	9,893,743	59.00
60.00	Primary payer payments	11,418	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	9,882,325	61.00
62.00	Deductibles billed to program beneficiaries	907,296	62.00
63.00	Coinsurance billed to program beneficiaries	1,484	63.00
64.00	Allowable bad debts (see instructions)	88,926	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	57,802	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,616	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	9,031,347	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	35,223	70.93
70.94	HRR adjustment amount (see instructions)	-30,622	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0097	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/27/2022 10:37 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2021	524,420	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2022	199,788	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		25,864	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,734,292	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		9,384,475	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		349,817	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		163,863	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,971,472	0	5,971,472		5,971,472	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,918,310	0		1,918,310	1,918,310	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	30,827	0	30,827		30,827	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	30,410	0		30,410	30,410	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	236,693	0	179,144	57,549	236,693	11.00
11.01	Uncompensated care payments	36.00	1,087,137	0	868,199	218,938	1,087,137	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,274,849	0	7,049,642	2,225,207	9,274,849	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,274,849	0	7,049,642	2,225,207	9,274,849	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	595,371	0	451,125	144,246	595,371	16.00
17.00	Special add-on payments for new technologies	54.00	23,523	0	23,523	0	23,523	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	7,524,290	2,369,453	9,893,743	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	592,920	0	450,800	142,120	592,920	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	2,451	0	325	2,126	2,451	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	595,371	0	451,125	144,246	595,371	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.069697	0.084318		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			524,420		524,420	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				199,788	199,788	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,971,472	5,971,472		5,971,472	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,918,310		1,918,310	1,918,310	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	30,827	30,827		30,827	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	30,410		30,410	30,410	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	236,693	179,144	57,549	236,693	11.00
11.01	Uncompensated care payments	36.00	1,087,137	868,199	218,938	1,087,137	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,274,849	7,049,642	2,225,207	9,274,849	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,274,849	7,049,642	2,225,207	9,274,849	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	595,371	451,125	144,246	595,371	16.00
17.00	Special add-on payments for new technologies	54.00	23,523	23,523	0	23,523	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			7,524,290	2,369,453	9,893,743	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	592,920	450,800	142,120	592,920	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	2,451	325	2,126	2,451	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	595,371	451,125	144,246	595,371	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	524,420	524,420		524,420	28.00
29.00	Low volume adjustment on or after October 1	70.97	199,788		199,788	199,788	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	35,223	0	35,223	35,223	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-30,622	-12,590	-18,032	-30,622	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	25,864	25,864	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0097	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/27/2022 10:37 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,035	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	14,083,322	2.00
3.00	OPPS payments	10,745,698	3.00
4.00	Outlier payment (see instructions)	42,620	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)	4,035	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	13,742	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)	13,742	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	13,742	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	9,707	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)	4,035	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)	10,788,318	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)	1,832,305	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)	8,960,048	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)	8,960,048	30.00
31.00	Primary payer payments	3,980	31.00
32.00	Subtotal (line 30 minus line 31)	8,956,068	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)	222,263	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	144,471	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	126,702	36.00
37.00	Subtotal (see instructions)	9,100,539	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-50	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	9,100,589	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	9,146,931	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-46,342	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2022 10:37 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		9,306,246		8,955,118	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/31/2021	7,929	12/31/2021	191,813	3.01
3.02		12/08/2021	70,300		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)		78,229		191,813	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)		9,384,475		9,146,931	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		349,817		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		46,342	6.02
7.00	Total Medicare program liability (see instructions)		9,734,292		9,100,589	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0097	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/27/2022 10:37 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0097	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2022 10:37 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	936,500		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)	936,500	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)	936,500	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	787,319		8.00
9.00	Ancillary service charges	2,076,009	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)	2,863,328	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)	2,863,328	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,926,828	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)	936,500	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)	936,500	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)	936,500	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	14,806	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)	921,694	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	921,694	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)	921,694	0	40.00
41.00	Interim payments	1,268,802	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-347,108	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: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/27/2022 10:37 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	13,352,171	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	53,035,254	0	0	0	4.00
5.00	Other receivable	8,637,500	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-35,606,903	0	0	0	6.00
7.00	Inventory	5,615,948	0	0	0	7.00
8.00	Prepaid expenses	2,315,067	0	0	0	8.00
9.00	Other current assets	4,221	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)	47,353,258	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,900,662	0	0	0	12.00
13.00	Land improvements	12,298,052	0	0	0	13.00
14.00	Accumulated depreciation	-5,254,759	0	0	0	14.00
15.00	Buildings	142,690,117	0	0	0	15.00
16.00	Accumulated depreciation	-30,515,034	0	0	0	16.00
17.00	Leasehold improvements	264,162	0	0	0	17.00
18.00	Accumulated depreciation	-249,430	0	0	0	18.00
19.00	Fixed equipment	5,846,210	0	0	0	19.00
20.00	Accumulated depreciation	-1,730,606	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	59,275,973	0	0	0	23.00
24.00	Accumulated depreciation	-39,375,414	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	146,149,933	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,525,057	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	376,314,888	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	377,839,945	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	571,343,136	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,447,003	0	0	0	37.00
38.00	Salaries, wages, and fees payable	12,608,015	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	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	84,432,314	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	102,487,332	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	96,163,621	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	96,163,621	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	198,650,953	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	372,692,183				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)	372,692,183	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	571,343,136	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 | Date/Time Prepared: 5/27/2022 10:37 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		313,352,084		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		60,940,034				2.00
3.00	Total (sum of line 1 and line 2)		374,292,118		0		3.00
4.00	OTHER ADDITION	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)		374,292,118		0		11.00
12.00	OTHER DEDUCTION	1,599,935		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)		1,599,935		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		372,692,183		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	OTHER ADDITION		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	OTHER DEDUCTION		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: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/27/2022 10:37 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	16,534,751		16,534,751	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)	16,534,751		16,534,751	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	7,565,552		7,565,552	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)	7,565,552		7,565,552	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	24,100,303		24,100,303	17.00
18.00	Ancillary services	80,752,954	387,607,665	468,360,619	18.00
19.00	Outpatient services	0	40,490	40,490	19.00
20.00	RURAL HEALTH CLINIC	0	4,653,569	4,653,569	20.00
20.01	RURAL HEALTH CLINIC II	0	0	0	20.01
20.02	RURAL HEALTH CLINIC III	0	0	0	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	104,853,257	392,301,724	497,154,981	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		158,632,773		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)		158,632,773		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-3 | Date/Time Prepared: 5/27/2022 10:37 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	497,154,981	1.00
2.00	Less contractual allowances and discounts on patients' accounts	328,710,491	2.00
3.00	Net patient revenues (line 1 minus line 2)	168,444,490	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	158,632,773	4.00
5.00	Net income from service to patients (line 3 minus line 4)	9,811,717	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	8,863,426	24.00
24.01	OTHER REVENUE	29,465,186	24.01
24.50	COVID-19 PHE Funding	21,226,375	24.50
25.00	Total other income (sum of lines 6-24)	59,554,987	25.00
26.00	Total (line 5 plus line 25)	69,366,704	26.00
27.00	TRANSFER	8,426,670	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	8,426,670	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	60,940,034	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0097	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 5/27/2022 10:37 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	592,920	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	2,451	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	30.88	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	595,371	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0097
Component CCN: 15-8529

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

Worksheet M-1

Date/Time Prepared:
5/27/2022 10:37 am

RHC I

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	218,812	789,907	1,008,719	61,926	1,070,645	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	103,204	0	103,204	0	103,204	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	55,483	0	55,483	0	55,483	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	704,516	0	704,516	0	704,516	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,082,015	789,907	1,871,922	61,926	1,933,848	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	405,495	405,495	0	405,495	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	405,495	405,495	0	405,495	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,082,015	1,195,402	2,277,417	61,926	2,339,343	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	66,905	66,905	0	66,905	29.00
30.00	Administrative Costs	248,002	106,809	354,811	0	354,811	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	248,002	173,714	421,716	0	421,716	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,330,017	1,369,116	2,699,133	61,926	2,761,059	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0097 | Component CCN: 15-8529 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/27/2022 10:37 am

RHC I

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,070,645		1.00
2.00	Physician Assistant	140,828	140,828		2.00
3.00	Nurse Practitioner	323,675	426,879		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	55,483		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	704,516		9.00
10.00	Subtotal (sum of lines 1 through 9)	464,503	2,398,351		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	405,495		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	405,495		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	464,503	2,803,846		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	66,905		29.00
30.00	Administrative Costs	305,332	660,143		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	305,332	727,048		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	769,835	3,530,894		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0097 | Component CCN: 15-8531 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/27/2022 10:37 am

RHC II

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	739,579	739,579	0	739,579	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	144,202	0	144,202	0	144,202	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	36,397	0	36,397	0	36,397	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	367,657	0	367,657	0	367,657	9.00
10.00	Subtotal (sum of lines 1 through 9)	548,256	739,579	1,287,835	0	1,287,835	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	319,440	319,440	0	319,440	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	319,440	319,440	0	319,440	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	548,256	1,059,019	1,607,275	0	1,607,275	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	16,805	16,805	0	16,805	29.00
30.00	Administrative Costs	57,067	64,749	121,816	0	121,816	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	57,067	81,554	138,621	0	138,621	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	605,323	1,140,573	1,745,896	0	1,745,896	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0097 | Component CCN: 15-8531 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/27/2022 10:37 am

RHC II

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-114,767	624,812		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	144,202		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	36,397		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	367,657		9.00
10.00	Subtotal (sum of lines 1 through 9)	-114,767	1,173,068		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	319,440		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	319,440		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-114,767	1,492,508		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	16,805		29.00
30.00	Administrative Costs	160,924	282,740		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	160,924	299,545		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	46,157	1,792,053		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0097
Component CCN: 15-8532

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

Worksheet M-1

Date/Time Prepared:
5/27/2022 10:37 am

RHC III

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	576,702	3,132,386	3,709,088	0	3,709,088	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	325,162	0	325,162	0	325,162	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	3,690	3,690	0	3,690	6.00
7.00	Clinical Social Worker	48,752	0	48,752	0	48,752	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	2,863,178	0	2,863,178	0	2,863,178	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,813,794	3,136,076	6,949,870	0	6,949,870	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	55,351	743,313	798,664	0	798,664	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	55,351	743,313	798,664	0	798,664	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,869,145	3,879,389	7,748,534	0	7,748,534	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	457,274	457,274	0	457,274	29.00
30.00	Administrative Costs	1,451,080	525,849	1,976,929	0	1,976,929	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,451,080	983,123	2,434,203	0	2,434,203	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,320,225	4,862,512	10,182,737	0	10,182,737	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0097 | Component CCN: 15-8532 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/27/2022 10:37 am

RHC III

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-262,448	3,446,640		1.00
2.00	Physician Assistant	168,413	168,413		2.00
3.00	Nurse Practitioner	1,178,960	1,504,122		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	3,690		6.00
7.00	Clinical Social Worker	0	48,752		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	2,863,178		9.00
10.00	Subtotal (sum of lines 1 through 9)	1,084,925	8,034,795		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	798,664		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	798,664		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,084,925	8,833,459		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	457,274		29.00
30.00	Administrative Costs	926,236	2,903,165		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	926,236	3,360,439		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,011,161	12,193,898		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0097
Component CCN: 15-8529

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

Worksheet M-2
Date/Time Prepared: 5/27/2022 10:37 am

RHC I

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	3.60	9,462	1	4		1.00
2.00	Physician Assistant	0.93	2,919	1	1		2.00
3.00	Nurse Practitioner	3.00	8,438	1	3		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.53	20,819		8	20,819	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.81	906			906	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	8.34	21,725			21,725	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,803,846	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,803,846	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					727,048	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,853,059	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,580,107	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,580,107	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,580,107	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					5,383,953	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0097 Component CCN: 15-8531

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

Worksheet M-2 Date/Time Prepared: 5/27/2022 10:37 am

RHC II

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.67	4,412	1	2		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.90	2,215	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.57	6,627		3	6,627	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.38	18			18	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.95	6,645			6,645	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,492,508	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,492,508	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					299,545	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					976,102	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,275,647	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,275,647	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,275,647	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,768,155	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0097 Component CCN: 15-8532

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

Worksheet M-2 Date/Time Prepared: 5/27/2022 10:37 am

RHC III

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	10.17	31,221	1	10		1.00
2.00	Physician Assistant	0.88	2,828	1	1		2.00
3.00	Nurse Practitioner	9.37	27,611	1	9		3.00
4.00	Subtotal (sum of lines 1 through 3)	20.42	61,660		20	61,660	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.74	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	21.16	61,660			61,660	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					8,833,459	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					8,833,459	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					3,360,439	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					6,530,024	15.00
16.00	Total overhead (sum of lines 14 and 15)					9,890,463	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					9,890,463	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					9,890,463	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					18,723,922	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0097 Component CCN: 15-8529	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/27/2022 10:37 am
	Title XVIII	RHC I	

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	5,383,953	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	521,839	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	4,862,114	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	21,725	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	21,725	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	223.80	7.00

		Calculation of Limit (1)		
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	248.98	8.00
9.00	Rate for Program covered visits (see instructions)	223.80	223.80	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	24	42	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	5,371	9,400	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	14,771	16.00
16.01	Total program charges (see instructions)(from contractor's records)		11,550	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		11,492	16.04
16.05	Total program cost (see instructions)	0	11,492	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		406	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		2,229	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		11,492	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		11,492	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		11,492	26.00
26.01	Sequestration adjustment (see instructions)		0	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		9,755	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		1,737	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0097 Component CCN: 15-8531	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/27/2022 10:37 am
	Title XVIII	RHC II	

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	2,768,155	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	4,634	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	2,763,521	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	6,645	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	6,645	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	415.88	7.00

		Calculation of Limit (1)		
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	448.83	8.00
9.00	Rate for Program covered visits (see instructions)	415.88	415.88	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	59	208	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	24,537	86,503	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	111,040	16.00
16.01	Total program charges (see instructions)(from contractor's records)		47,806	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		10,038	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		23,316	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		68,713	16.04
16.05	Total program cost (see instructions)	0	92,029	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,833	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		7,187	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		92,029	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		221	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		92,250	22.00
23.00	Allowable bad debts (see instructions)		28	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		18	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		92,268	26.00
26.01	Sequestration adjustment (see instructions)		0	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		72,405	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		19,863	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0097 Component CCN: 15-8532	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/27/2022 10:37 am
	Title XVIII	RHC III	

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	18,723,922	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	665,992	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	18,057,930	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	61,660	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	61,660	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	292.86	7.00

		Calculation of Limit (1)		
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	344.81	8.00
9.00	Rate for Program covered visits (see instructions)	292.86	292.86	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	3,627	11,813	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	1,062,203	3,459,555	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	4,521,758	16.00
16.01	Total program charges (see instructions)(from contractor's records)		3,807,983	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		624,781	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		741,889	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		2,865,239	16.04
16.05	Total program cost (see instructions)	0	3,607,128	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		198,320	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		596,977	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		3,607,128	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		202,272	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		3,809,400	22.00
23.00	Allowable bad debts (see instructions)		968	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		629	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		3,810,029	26.00
26.01	Sequestration adjustment (see instructions)		0	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		4,076,023	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		-265,994	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0097 | Component CCN: 15-8529 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | RHC I

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,398,351	2,398,351	2,398,351	2,398,351	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.005199	0.005814	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	12,469	13,944	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	157,867	87,482	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	170,336	101,426	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,803,846	2,803,846	2,803,846	2,803,846	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,580,107	2,580,107	2,580,107	2,580,107	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.060751	0.036174	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	156,744	93,333	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	327,080	194,759	0	0	10.00
11.00	Total number of injections/infusions (from your records)	1,589	1,777	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	205.84	109.60	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	0	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	0	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		521,839			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		0			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0097 | Component CCN: 15-8531 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | RHC II

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,173,068	1,173,068	1,173,068	1,173,068	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000367	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	431	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	2,068	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	2,499	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,492,508	1,492,508	1,492,508	1,492,508	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,275,647	1,275,647	1,275,647	1,275,647	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.001674	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	2,135	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	4,634	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	42	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	110.33	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	2	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	221	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		4,634			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		221			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0097 | Component CCN: 15-8532 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/27/2022 10:37 am

Title XVIII | RHC III

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	8,034,795	8,034,795	8,034,795	8,034,795	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000905	0.004100	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	7,271	32,943	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	84,448	189,536	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	91,719	222,479	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	8,833,459	8,833,459	8,833,459	8,833,459	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	9,890,463	9,890,463	9,890,463	9,890,463	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.010383	0.025186	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	102,693	249,101	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	194,412	471,580	0	0	10.00
11.00	Total number of injections/infusions (from your records)	849	3,841	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	228.99	122.78	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	308	1,073	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	70,529	131,743	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		665,992			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		202,272			16.00

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

Provider CCN: 15-0097
Component CCN: 15-8529

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

Worksheet M-5

Date/Time Prepared: 5/27/2022 10:37 am

RHC I

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		9,755	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		9,755	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		1,737	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		11,492	7.00

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

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

Provider CCN: 15-0097
Component CCN: 15-8531

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

Worksheet M-5

Date/Time Prepared: 5/27/2022 10:37 am

RHC II

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		72,405	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		72,405	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		19,863	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		92,268	7.00

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

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

Provider CCN: 15-0097
Component CCN: 15-8532

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

Worksheet M-5

Date/Time Prepared: 5/27/2022 10:37 am

RHC III

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		3,275,723	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		12/14/2021	800,300	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		800,300	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		4,076,023	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		265,994	6.02
7.00	Total Medicare program liability (see instructions)		3,810,029	7.00

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