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: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/30/2021 2:40 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/30/2021 Time: 2:40 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSP & HEALTH CARE CTR (15-0115) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	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	1,399,761	118,320	0	0	1.00
2.00	Subprovider - IPF	0	47,499	0		0	2.00
3.00	Subprovider - IRF	0	-9,108	1		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	2,452	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	-1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		13,333		0	10.00
10.01	RURAL HEALTH CLINIC II	0		18,895		0	10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	1,440,604	150,548	0	0	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: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 2:40 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 800 WEST 9TH STREET	PO Box:			1.00
2.00	City: JASPER	State: IN	Zip Code: 47546	County: DUBOIS	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	MEMORIAL HOSP & HEALTH CARE CTR	150115	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	MEMORIAL HOSP & HCC (PSYCH)	15S115	99915	4	07/01/1985	N	P	O	4.00
5.00	Subprovider - IRF	MEMORIAL HOSP & HCC (REHAB)	15T115	99915	5	07/01/2005	N	P	O	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	MEMORIAL HOSP & HEALTH CARE CTR	155305	99915		08/04/1987	N	P	O	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	MEMORIAL HOSP & HEALTH CARE CTR	157222	99915		08/28/1991	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FRENCH LICK FAMILY MEDICINE	158507	99915		06/19/2009	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	LOOGOOTEE FAMILY MEDICINE	158508	99915		12/14/2009	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2020	06/30/2021	20.00
21.00	Type of Control (see instructions)	1		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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 OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 2:40 pm

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	309	249	0	0	1,837	161	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	36	0	0	47		25.00

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

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

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	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.	Y	Y		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.	Y	Y		57.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 2:40 pm

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

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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)	Y	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 2:40 pm

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.63	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)	FAMILY MEDICINE	1350	2.38	6.85	0.257855	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I | Date/Time Prepared: 11/30/2021 2:40 pm

		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.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	Y	1	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.	Y			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)	N	N	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)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 2:40 pm

				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.					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.		Y			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:		1,201,208	0	0	118.01
				1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N		118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.			N		122.00
	Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 2:40 pm

		1.00	2.00	
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: MEMORIAL HOSPITAL AND HEALTH CENTER	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 800 W 9TH STREET	PO Box:		142.00
143.00	City: JASPER	State: IN	Zip Code: 47546	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: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 2:40 pm

		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: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part II | Date/Time Prepared: 11/30/2021 2:40 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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 nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	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	09/30/2021	Y	09/30/2021	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 2:40 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KERRY	BEJARANO	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(317) 383-4000	KBEJARANO@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 2:40 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I | Date/Time Prepared: 11/30/2021 2:40 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	70	25,550	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)		70	25,550	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	26	9,490	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	43.00				0	13.00
14.00	Total (see instructions)		96	35,040	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	19	6,935		0	16.00
17.00	SUBPROVIDER - IRF	41.00	8	2,920		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	14	5,110		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		137				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: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I | Date/Time Prepared: 11/30/2021 2:40 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,624	161	8,651			1.00
2.00	HMO and other (see instructions)	1,418	2,086				2.00
3.00	HMO IPF Subprovider	105	0				3.00
4.00	HMO IRF Subprovider	199	83				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)	3,624	161	8,651			7.00
8.00	INTENSIVE CARE UNIT	1,924	84	4,094			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		64	1,378			13.00
14.00	Total (see instructions)	5,548	309	14,123	9.35	968.27	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	884	712	2,266	0.51	22.56	16.00
17.00	SUBPROVIDER - IRF	517	0	1,097	0.00	8.05	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,459	100	4,334	0.00	20.43	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	12,439	0	18,805	0.00	32.05	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			109			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,323	0	4,043	0.00	4.78	26.00
26.01	RURAL HEALTH CLINIC II	1,446	0	4,443	0.00	6.76	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				9.86	1,062.90	27.00
28.00	Observation Bed Days		45	2,646			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	161	369			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: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I | Date/Time Prepared: 11/30/2021 2:40 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,773	439	3,952	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,773	439	3,952	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	106	190	481	16.00
17.00	SUBPROVIDER - IRF	0.00	0	43	0	82	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	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: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part II | Date/Time Prepared: 11/30/2021 2:40 pm

		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	95,982,355	-960,847	95,021,508	2,179,218.50	43.60	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		3,589,814	0	3,589,814	32,681.00	109.84	3.00
4.00	Physician-Part A - Administrative		232,475	0	232,475	781.00	297.66	4.00
4.01	Physicians - Part A - Teaching		887,599	0	887,599	7,061.00	125.70	4.01
5.00	Physician and Non Physician-Part B		10,468,833	0	10,468,833	35,546.93	294.51	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		560,651	0	560,651	15,814.00	35.45	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)		832,537	0	832,537	19,448.00	42.81	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	1,279,191	-5,682	1,273,509	41,495.33	30.69	9.00
10.00	Excluded area salaries (see instructions)		36,420,684	-269,463	36,151,221	750,906.12	48.14	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,174,043	0	2,174,043	42,063.00	51.69	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		132,271	0	132,271	1,050.00	125.97	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		11,287,484	0	11,287,484	472,589.26	23.88	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)		12,691,599	0	12,691,599			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		7,087,570	0	7,087,570			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		303,311	0	303,311			21.00
22.00	Physician Part A - Administrative		8,253	0	8,253			22.00
22.01	Physician Part A - Teaching		66,027	0	66,027			22.01
23.00	Physician Part B		330,134	0	330,134			23.00
24.00	Wage-related costs (RHC/FQHC)		146,497	0	146,497			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		2,354,569	0	2,354,569			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: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part II Date/Time Prepared: 11/30/2021 2:40 pm

		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	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	3,718,443	-12,978	3,705,465	107,783.40	34.38	27.00
28.00	Administrative & General under contract (see inst.)		946,309	0	946,309	9,562.07	98.96	28.00
29.00	Maintenance & Repairs	6.00	529,923	0	529,923	6,711.75	78.95	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	296,807	-2,706	294,101	19,916.21	14.77	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,735,413	0	1,735,413	90,249.32	19.23	33.00
34.00	Dietary	10.00	1,057,642	-839,005	218,637	12,603.70	17.35	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	814,279	814,279	46,852.00	17.38	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	858,516	-13,697	844,819	21,943.85	38.50	38.00
39.00	Central Services and Supply	14.00	275,242	-7,417	267,825	13,017.56	20.57	39.00
40.00	Pharmacy	15.00	1,937,382	-45,478	1,891,904	47,595.78	39.75	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	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: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part III Date/Time Prepared: 11/30/2021 2:40 pm

		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)		82,324,643	-960,847	81,363,796	2,168,478.96	37.52	1.00
2.00	Excluded area salaries (see instructions)		37,699,875	-275,145	37,424,730	792,401.45	47.23	2.00
3.00	Subtotal salaries (line 1 minus line 2)		44,624,768	-685,702	43,939,066	1,376,077.51	31.93	3.00
4.00	Subtotal other wages & related costs (see inst.)		13,593,798	0	13,593,798	515,702.26	26.36	4.00
5.00	Subtotal wage-related costs (see inst.)		15,054,421	0	15,054,421	0.00	34.26	5.00
6.00	Total (sum of lines 3 thru 5)		73,272,987	-685,702	72,587,285	1,891,779.77	38.37	6.00
7.00	Total overhead cost (see instructions)		11,355,677	-107,002	11,248,675	376,235.64	29.90	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part IV Date/Time Prepared: 11/30/2021 2:40 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,557,372	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	-1,493	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)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	11,120,408	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	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	80,558	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)	1,289,201	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	312,430	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	5,979,451	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	81,373	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	214,091	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	20,633,391	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: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part V | Date/Time Prepared: 11/30/2021 2:40 pm

	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	2,174,043	20,633,391	1.00
2.00	Hospital	2,174,043	20,633,391	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	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	0	0	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	0	0	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
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-0115 | Component CCN: 15-7222 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-4 | Date/Time Prepared: 11/30/2021 2:40 pm

Home Health Agency I | PPS

		1.00	
0.00	County	DUBOIS	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	5,509	603	794	6,906	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	722.00	79.00	104.00	905.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		1.03	0.00	1.03	4.00
5.00	Other Administrative Personnel		4.81	0.00	4.81	5.00
6.00	Direct Nursing Service		12.77	0.00	12.77	6.00
7.00	Nursing Supervisor		0.81	0.00	0.81	7.00
8.00	Physical Therapy Service		5.90	0.00	5.90	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		3.07	0.00	3.07	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.16	0.00	0.16	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.17	0.00	0.17	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		3.32	0.00	3.32	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99915			20.00

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	4,094	1,084	132	12	5,322	21.00
22.00	Skilled Nursing Visit Charges	1,033,188	274,804	35,451	3,024	1,346,467	22.00
23.00	Physical Therapy Visits	2,169	1,130	24	2	3,325	23.00
24.00	Physical Therapy Visit Charges	584,920	303,492	6,753	538	895,703	24.00
25.00	Occupational Therapy Visits	824	906	8	0	1,738	25.00
26.00	Occupational Therapy Visit Charges	221,188	243,077	2,152	0	466,417	26.00
27.00	Speech Pathology Visits	25	48	1	0	74	27.00
28.00	Speech Pathology Visit Charges	6,712	12,873	269	0	19,854	28.00
29.00	Medical Social Service Visits	22	5	0	0	27	29.00
30.00	Medical Social Service Visit Charges	6,732	1,530	0	0	8,262	30.00
31.00	Home Health Aide Visits	1,331	617	3	2	1,953	31.00
32.00	Home Health Aide Visit Charges	155,321	71,930	351	234	227,836	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	8,465	3,790	168	16	12,439	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	2,008,061	907,706	44,976	3,796	2,964,539	35.00
36.00	Total Number of Episodes (standard/non outlier)	783		93	3	879	36.00
37.00	Total Number of Outlier Episodes		160		0	160	37.00
38.00	Total Non-Routine Medical Supply Charges	94,519	18,186	1,850	273	114,828	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0115 | Component CCN: 15-8507 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-8 | Date/Time Prepared: 11/30/2021 2:40 pm

RHC I | Cost

					1.00		
	Clinic Address and Identification						
1.00	Street				522 SOUTH MAPLE STREET		1.00
			City		State	ZIP Code	
			1.00		2.00	3.00	
2.00	City, State, ZIP Code, County		FRENCH LICK		IN	47432	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	07:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
					Provider name	CCN number	
					1.00	2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		ORANGE				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:00	08:00	12:00	07:00	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0115
Component CCN: 15-8507

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

Worksheet S-8
Date/Time Prepared:
11/30/2021 2:40 pm

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	06:00	15:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0115 | Component CCN: 15-8508 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-8 | Date/Time Prepared: 11/30/2021 2:40 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			105 COOPER STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	LOOGOOTEE		IN	47553	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		MARTIN				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: 15-0115
Component CCN: 15-8508

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

Worksheet S-8
Date/Time Prepared:
11/30/2021 2:40 pm

RHC II | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	13:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-10 | Date/Time Prepared: 11/30/2021 2:40 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.246605	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	10,649,705	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	88,230,525	6.00
7.00	Medicaid cost (line 1 times line 6)	21,758,089	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)	11,108,384	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)	11,108,384	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)	2,760,551	1,417,910	4,178,461	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	680,766	1,417,910	2,098,676	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)	680,766	1,417,910	2,098,676	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)	10,039,632	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	278,751	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	428,847	27.01
28.00	Non-Medicare bad debt expense (see instructions)	9,610,785	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,520,164	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,618,840	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	15,727,224	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A | Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		6,831,597	6,831,597	0	6,831,597	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,529,859	5,529,859	0	5,529,859	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,718,443	2,112,883	5,831,326	-258	5,831,068	5.00
6.00	00600	MAINTENANCE & REPAIRS	529,923	3,204,950	3,734,873	0	3,734,873	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	296,807	68,920	365,727	0	365,727	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	1,057,642	547,397	1,605,039	-1,241,671	363,368	10.00
11.00	01100	CAFETERIA	0	0	0	1,235,720	1,235,720	11.00
13.00	01300	NURSING ADMINISTRATION	858,516	65,081	923,597	-516	923,081	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	275,242	153,517	428,759	-12,931	415,828	14.00
15.00	01500	PHARMACY	1,937,382	18,821,943	20,759,325	-18,603,335	2,155,990	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	832,537	832,537	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	951,842	867,277	1,819,119	-832,541	986,578	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,290,583	674,365	7,964,948	-2,027,505	5,937,443	30.00
31.00	03100	INTENSIVE CARE UNIT	2,748,046	204,471	2,952,517	-99,857	2,852,660	31.00
40.00	04000	SUBPROVIDER - IPF	1,653,256	49,641	1,702,897	-3,760	1,699,137	40.00
41.00	04100	SUBPROVIDER - IRF	637,847	159,742	797,589	-4,142	793,447	41.00
43.00	04300	NURSERY	0	0	0	616,339	616,339	43.00
44.00	04400	SKILLED NURSING FACILITY	1,279,191	82,495	1,361,686	-30,184	1,331,502	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,817,996	10,319,234	15,137,230	-71,010	15,066,220	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,232,677	1,232,677	52.00
53.00	05300	ANESTHESIOLOGY	4,114,910	380,984	4,495,894	-1,443	4,494,451	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,458,654	1,438,496	7,897,150	-236,685	7,660,465	54.00
56.00	05600	RADIOISOTOPE	172,048	541,104	713,152	-1,013	712,139	56.00
60.00	06000	LABORATORY	2,617,088	5,115,437	7,732,525	-5,054	7,727,471	60.00
65.00	06500	RESPIRATORY THERAPY	1,293,776	617,340	1,911,116	-21,722	1,889,394	65.00
66.00	06600	PHYSICAL THERAPY	2,578,938	173,417	2,752,355	-97,223	2,655,132	66.00
69.00	06900	ELECTROCARDIOLOGY	2,693,030	2,513,336	5,206,366	-73,047	5,133,319	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	98,746	61,235	159,981	0	159,981	69.02
69.03	06903	SLEEP LAB	268,135	25,029	293,164	0	293,164	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,280,938	1,280,938	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,492,184	5,492,184	0	5,492,184	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	18,834,489	18,834,489	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	380,806	99,005	479,811	0	479,811	88.00
88.01	08801	RURAL HEALTH CLINIC II	472,041	55,946	527,987	0	527,987	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	451,973	839,894	1,291,867	-275,734	1,016,133	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	2,311,492	897,522	3,209,014	-78,882	3,130,132	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	1,357,137	156,766	1,513,903	-21,339	1,492,564	90.04
90.05	09005	DIABETES MGMT CLINIC	64,622	2,061	66,683	-33	66,650	90.05
91.00	09100	EMERGENCY	8,466,662	1,225,488	9,692,150	-216,431	9,475,719	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,033,203	151,720	2,184,923	-19,137	2,165,786	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	1,983,501	354,722	2,338,223	-57,247	2,280,976	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	65,869,478	69,835,058	135,704,536	0	135,704,536	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	27,846,342	5,092,458	32,938,800	0	32,938,800	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	995,770	39,845	1,035,615	0	1,035,615	192.01
194.00	07950	LODGE	4,565	10,757	15,322	0	15,322	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	94,264	5,150	99,414	0	99,414	194.02
194.03	07953	MKT/PHY SERVICES	203,733	57,041	260,774	0	260,774	194.03
194.04	07954	COMMUNITY EDUCATION	334,392	129,485	463,877	0	463,877	194.04
194.05	07955	VOLUNTEER	228,371	18,927	247,298	0	247,298	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	96,518	15,259	111,777	0	111,777	194.07

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A | Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	308,922	1,187,604	1,496,526	0	1,496,526	194.10
194.11	07961	HOME OFFICE	0	0	0	0	0	194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	95,982,355	76,391,584	172,373,939	0	172,373,939	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A | Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,634,044	11,465,641		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,759	5,532,618		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	22,991,782	22,991,782		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,303,657	24,134,725		5.00
6.00	00600	MAINTENANCE & REPAIRS	4,845,718	8,580,591		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	365,727		8.00
9.00	00900	HOUSEKEEPING	1,697,053	1,697,053		9.00
10.00	01000	DIETARY	-18,632	344,736		10.00
11.00	01100	CAFETERIA	-551,202	684,518		11.00
13.00	01300	NURSING ADMINISTRATION	-8,319	914,762		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-2,580	413,248		14.00
15.00	01500	PHARMACY	-303,188	1,852,802		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,738,031	1,738,031		16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	832,537		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	-57,413	929,165		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-213,529	5,723,914		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,852,660		31.00
40.00	04000	SUBPROVIDER - IPF	-325,016	1,374,121		40.00
41.00	04100	SUBPROVIDER - IRF	-57,358	736,089		41.00
43.00	04300	NURSERY	0	616,339		43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,331,502		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,488,258	13,577,962		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,232,677		52.00
53.00	05300	ANESTHESIOLOGY	-3,966,657	527,794		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,243,212	3,417,253		54.00
56.00	05600	RADIOISOTOPE	0	712,139		56.00
60.00	06000	LABORATORY	-190,178	7,537,293		60.00
65.00	06500	RESPIRATORY THERAPY	-9,938	1,879,456		65.00
66.00	06600	PHYSICAL THERAPY	-295,469	2,359,663		66.00
69.00	06900	ELECTROCARDIOLOGY	-694,923	4,438,396		69.00
69.01	06901	PULMONARY	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	159,981		69.02
69.03	06903	SLEEP LAB	-3,662	289,502		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,280,938		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,492,184		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,834,489		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-666	479,145		88.00
88.01	08801	RURAL HEALTH CLINIC II	-838	527,149		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	-372,156	643,977		90.00
90.01	09001	IMED	0	0		90.01
90.02	09002	ONCOLOGY	0	3,130,132		90.02
90.03	09003	OUTPATIENT CENTER	0	0		90.03
90.04	09004	HBURG URGENT CARE CLINIC	-318,264	1,174,300		90.04
90.05	09005	DIABETES MGMT CLINIC	0	66,650		90.05
91.00	09100	EMERGENCY	-5,210,478	4,265,241		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-385,802	1,779,984		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
101.00	10100	HOME HEALTH AGENCY	0	2,280,976		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,495,306	171,199,842		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	32,938,800		192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,035,615		192.01
194.00	07950	LODGE	0	15,322		194.00
194.01	07951	OTHER NRCC	0	0		194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	99,414		194.02
194.03	07953	MKT/PHY SERVICES	3,815,782	4,076,556		194.03
194.04	07954	COMMUNITY EDUCATION	0	463,877		194.04
194.05	07955	VOLUNTEER	0	247,298		194.05
194.06	07956	MAB	0	0		194.06
194.07	07957	OFFSITE COVID SCREENING	0	111,777		194.07
194.08	07958	PUBLIC RELATIONS	0	0		194.08
194.09	07959	UNUSED SPACE	0	0		194.09

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A | Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
194.10	07960	EMERGENCY PREPAREDNESS	0	1,496,526		194.10
194.11	07961	HOME OFFICE	0	0		194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	39,311,088	211,685,027		200.00

RECLASSIFICATIONS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-6 | Date/Time Prepared: 11/30/2021 2:40 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LABOR AND DELIVERY				
1.00	NURSERY	43.00	548,801	67,538	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,097,601	135,076	2.00
	0		1,646,402	202,614	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	814,279	421,441	1.00
	0		814,279	421,441	
	C - BILLABLE SUPPLES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,280,938	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	0		0	1,280,938	
	D - DRUGS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	18,834,489	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
	0		0	18,834,489	
	E - INTERN AND RESIDENT RECLASS				
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	832,537	1.00
	0		0	832,537	
	F - DISABILITY LEAVE RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,978	1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	0	2,706	2.00
3.00	DIETARY	10.00	0	24,726	3.00
4.00	NURSING ADMINISTRATION	13.00	0	13,697	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,417	5.00
6.00	PHARMACY	15.00	0	45,478	6.00
7.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	1,020	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	102,655	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	20,423	9.00
10.00	SUBPROVIDER - IPF	40.00	0	21,807	10.00
11.00	SUBPROVIDER - IRF	41.00	0	11,225	11.00
12.00	SKILLED NURSING FACILITY	44.00	0	5,682	12.00

RECLASSIFICATIONS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-6 | Date/Time Prepared: 11/30/2021 2:40 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
13.00	OPERATING ROOM	50.00	0	71,154		13.00
14.00	ANESTHESIOLOGY	53.00	0	60,505		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	54,595		15.00
16.00	LABORATORY	60.00	0	27,038		16.00
17.00	RESPIRATORY THERAPY	65.00	0	20,726		17.00
18.00	PHYSICAL THERAPY	66.00	0	72,586		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	38,096		19.00
20.00	SLEEP LAB	69.03	0	991		20.00
21.00	RURAL HEALTH CLINIC	88.00	0	10,700		21.00
22.00	RURAL HEALTH CLINIC II	88.01	0	26,405		22.00
23.00	CLINIC	90.00	0	8,313		23.00
24.00	ONCOLOGY	90.02	0	39,655		24.00
25.00	HBURG URGENT CARE CLINIC	90.04	0	19,414		25.00
26.00	EMERGENCY	91.00	0	4,424		26.00
27.00	AMBULANCE SERVICES	95.00	0	16,866		27.00
28.00	HOME HEALTH AGENCY	101.00	0	35,418		28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	165,806		29.00
30.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	192.01	0	3,465		30.00
31.00	COMMUNITY EDUCATION	194.04	0	1,782		31.00
32.00	VOLUNTEER	194.05	0	12,434		32.00
33.00	EMERGENCY PREPAREDNESS	194.10	0	660		33.00
	TOTALS		0	960,847		
500.00	Grand Total: Increases		2,460,681	22,532,866		500.00

RECLASSIFICATIONS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-6 | Date/Time Prepared: 11/30/2021 2:40 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	1,646,402	202,614	0		1.00
2.00		0.00	0	0	0		2.00
	0		1,646,402	202,614			
	B - CAFETERIA						
1.00	DIETARY	10.00	814,279	421,441	0		1.00
	0		814,279	421,441			
	C - BILLABLE SUPPLES						
1.00	NURSING ADMINISTRATION	13.00	0	516	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	12,827	0		2.00
3.00	PHARMACY	15.00	0	2,855	0		3.00
4.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	4	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	177,959	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	99,821	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	3,748	0		7.00
8.00	SUBPROVIDER - IRF	41.00	0	4,142	0		8.00
9.00	SKILLED NURSING FACILITY	44.00	0	30,184	0		9.00
10.00	OPERATING ROOM	50.00	0	70,114	0		10.00
11.00	ANESTHESIOLOGY	53.00	0	1,443	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	113,985	0		12.00
13.00	RADIOISOTOPE	56.00	0	610	0		13.00
14.00	LABORATORY	60.00	0	59	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	4,432	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	93,798	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	50,162	0		17.00
18.00	CLINIC	90.00	0	260,221	0		18.00
19.00	ONCOLOGY	90.02	0	78,256	0		19.00
20.00	HBURG URGENT CARE CLINIC	90.04	0	6,649	0		20.00
21.00	DIABETES MGMT CLINIC	90.05	0	33	0		21.00
22.00	EMERGENCY	91.00	0	203,854	0		22.00
23.00	AMBULANCE SERVICES	95.00	0	9,312	0		23.00
24.00	HOME HEALTH AGENCY	101.00	0	55,954	0		24.00
	0		0	1,280,938			
	D - DRUGS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	258	0		1.00
2.00	DIETARY	10.00	0	5,951	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	104	0		3.00
4.00	PHARMACY	15.00	0	18,600,480	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	530	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	36	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	12	0		7.00
8.00	OPERATING ROOM	50.00	0	896	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	122,700	0		9.00
10.00	RADIOISOTOPE	56.00	0	403	0		10.00
11.00	LABORATORY	60.00	0	4,995	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	17,290	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	3,425	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	22,885	0		14.00
15.00	CLINIC	90.00	0	15,513	0		15.00
16.00	ONCOLOGY	90.02	0	626	0		16.00
17.00	HBURG URGENT CARE CLINIC	90.04	0	14,690	0		17.00
18.00	EMERGENCY	91.00	0	12,577	0		18.00
19.00	AMBULANCE SERVICES	95.00	0	9,825	0		19.00
20.00	HOME HEALTH AGENCY	101.00	0	1,293	0		20.00
	0		0	18,834,489			
	E - INTERN AND RESIDENT RECLASS						
1.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	832,537	0		1.00
	0		0	832,537			
	F - DISABILITY LEAVE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	12,978	0	0		1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	2,706	0	0		2.00
3.00	DIETARY	10.00	24,726	0	0		3.00
4.00	NURSING ADMINISTRATION	13.00	13,697	0	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	7,417	0	0		5.00
6.00	PHARMACY	15.00	45,478	0	0		6.00
7.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	1,020	0	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	102,655	0	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	20,423	0	0		9.00
10.00	SUBPROVIDER - IPF	40.00	21,807	0	0		10.00
11.00	SUBPROVIDER - IRF	41.00	11,225	0	0		11.00
12.00	SKILLED NURSING FACILITY	44.00	5,682	0	0		12.00

RECLASSIFICATIONS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-6 | Date/Time Prepared: 11/30/2021 2:40 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
13.00	OPERATING ROOM	50.00	71,154	0	0		13.00
14.00	ANESTHESIOLOGY	53.00	60,505	0	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	54,595	0	0		15.00
16.00	LABORATORY	60.00	27,038	0	0		16.00
17.00	RESPIRATORY THERAPY	65.00	20,726	0	0		17.00
18.00	PHYSICAL THERAPY	66.00	72,586	0	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	38,096	0	0		19.00
20.00	SLEEP LAB	69.03	991	0	0		20.00
21.00	RURAL HEALTH CLINIC	88.00	10,700	0	0		21.00
22.00	RURAL HEALTH CLINIC II	88.01	26,405	0	0		22.00
23.00	CLINIC	90.00	8,313	0	0		23.00
24.00	ONCOLOGY	90.02	39,655	0	0		24.00
25.00	HBURG URGENT CARE CLINIC	90.04	19,414	0	0		25.00
26.00	EMERGENCY	91.00	4,424	0	0		26.00
27.00	AMBULANCE SERVICES	95.00	16,866	0	0		27.00
28.00	HOME HEALTH AGENCY	101.00	35,418	0	0		28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	165,806	0	0		29.00
30.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	192.01	3,465	0	0		30.00
31.00	COMMUNITY EDUCATION	194.04	1,782	0	0		31.00
32.00	VOLUNTEER	194.05	12,434	0	0		32.00
33.00	EMERGENCY PREPAREDNESS	194.10	660	0	0		33.00
	TOTALS		960,847	0			
500.00	Grand Total: Decreases		3,421,528	21,572,019			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part I | Date/Time Prepared: 11/30/2021 2:40 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	11,046,937	107,626	0	107,626	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	121,307,544	298,147	0	298,147	0	3.00
4.00	Building Improvements	1,172,693	29,637,067	0	29,637,067	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	103,337,152	11,441,558	0	11,441,558	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	236,864,326	41,484,398	0	41,484,398	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	236,864,326	41,484,398	0	41,484,398	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	11,154,563	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	121,605,691	0	3.00
4.00	Building Improvements	30,809,760	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	114,778,710	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	278,348,724	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	278,348,724	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part II | Date/Time Prepared: 11/30/2021 2:40 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,551,746	824,276	2,309,937	145,638	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,529,859	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	9,081,605	824,276	2,309,937	145,638	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	6,831,597	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,529,859	2.00
3.00	Total (sum of lines 1-2)	0	12,361,456	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part III Date/Time Prepared: 11/30/2021 2:40 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	163,570,014	0	163,570,014	0.587644	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	114,778,710	0	114,778,710	0.412356	0	2.00
3.00	Total (sum of lines 1-2)	278,348,724	0	278,348,724	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	10,495,727	824,276	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,532,618	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	16,028,345	824,276	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	145,638	0	0	11,465,641	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,532,618	2.00
3.00	Total (sum of lines 1-2)	0	145,638	0	0	16,998,259	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8 | Date/Time Prepared: 11/30/2021 2:40 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-2,309,937	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		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	0	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	-12,955,296			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-6,936	ADMINISTRATIVE & GENERAL	5.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	62,177,396			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-551,202	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-303,188	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-15,207	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	0	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ADVERTISING - NURSING ADMIN	A	-2,614	NURSING ADMINISTRATION	13.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8 | Date/Time Prepared: 11/30/2021 2:40 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	ADVERTISING - SKILLED NURSING	A	-50	ADULTS & PEDIATRICS	30.00	0	33.01
33.02	ADVERTISING - CARING HANDS	A	-100	SUBPROVIDER - IPF	40.00	0	33.02
33.03	ADVERTISING - PT	A	-236	PHYSICAL THERAPY	66.00	0	33.03
33.04	ADVERTISING - SLEEP CENTER	A	-712	SLEEP LAB	69.03	0	33.04
33.05	ADVERTISING - FRENCH LICK	A	-400	RURAL HEALTH CLINIC	88.00	0	33.05
33.06	ADVERTISING - LOOGOOTEE	A	-838	RURAL HEALTH CLINIC II	88.01	0	33.06
33.07	ADVERTISING - WOUND CARE	A	-580	CLINIC	90.00	0	33.07
33.08	ADVERTISING - HUNTINGBURG	A	-236	HBURG URGENT CARE CLINIC	90.04	0	33.08
33.09	ADVERTISING - AMBULANCE	A	-4,557	AMBULANCE SERVICES	95.00	0	33.09
33.10	PHYSICIAN RECRUITMENT	A	-685	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	33.10
33.11	MISCELLANEOUS REVENUE - ADMIN	B	-409,410	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	MISCELLANEOUS - ENGINEERING	B	-18,958	MAINTENANCE & REPAIRS	6.00	0	33.12
33.13	MISCELLANEOUS - DIETARY	B	-18,632	DIETARY	10.00	0	33.13
33.15	MISCELLANEOUS - CLINICAL	B	-5,705	NURSING ADMINISTRATION	13.00	0	33.15
33.16	MISCELLANEOUS - STERILE PROC	B	-2,580	CENTRAL SERVICES & SUPPLY	14.00	0	33.16
33.17	MISCELLANEOUS - PERINATAL SVCS	B	-213,479	ADULTS & PEDIATRICS	30.00	0	33.17
33.18	MISCELLANEOUS - REHAB	B	-24,062	SUBPROVIDER - IRF	41.00	0	33.18
33.19	MISCELLANEOUS - RADIOLOGY	B	-327	RADIOLOGY-DIAGNOSTIC	54.00	0	33.19
33.20	MISCELLANEOUS - LABS	B	-40,178	LABORATORY	60.00	0	33.20
33.21	MISCELLANEOUS - THERAPY	B	-295,233	PHYSICAL THERAPY	66.00	0	33.21
33.22	MISCELLANEOUS - SLEEP LAB	B	-2,950	SLEEP LAB	69.03	0	33.22
33.23	MISCELLANEOUS - FRENCH LICK	B	-266	RURAL HEALTH CLINIC	88.00	0	33.23
33.25	MISCELLANEOUS - HBURG URGENT CARE CL	B	-15,914	HBURG URGENT CARE CLINIC	90.04	0	33.25
33.26	MISCELLANEOUS - AMBULANCE	B	-380,039	AMBULANCE SERVICES	95.00	0	33.26
33.27	CRNA EXPENSE	A	-917,175	OPERATING ROOM	50.00	0	33.27
33.28	CRNA EXPENSE	A	-2,672,639	ANESTHESIOLOGY	53.00	0	33.28
33.29	I/R START UP COSTS AMORTIZATION	A	2,759	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.29
33.30	I/R START UP COSTS AMORTIZATION	A	11,370	MAINTENANCE & REPAIRS	6.00	0	33.30
33.31	I/R START UP COSTS AMORTIZATION	A	219,884	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	33.31
33.32	GAINSHARE	A	-1,930,000	ADMINISTRATIVE & GENERAL	5.00	0	33.32
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		39,311,088				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: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-1 | Date/Time Prepared: 11/30/2021 2:40 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	AMBULATORY SURGERY CENTER	3,956,099	4,483,848	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL	6,943,981	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFITS	22,991,782	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	A&G	20,650,003	0	4.00
4.01	6.00	MAINTENANCE & REPAIRS	PLANT ENGINEERING	4,853,306	0	4.01
4.02	9.00	HOUSEKEEPING	ENVIRONMENTAL SERVICES	1,697,053	0	4.02
4.03	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	1,753,238	0	4.03
4.04	194.03	MKT/PHY SERVICES	PHYSICIAN SERVICES	3,815,782	0	4.04
4.05	0.00			0	0	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			66,661,244	4,483,848	5.00

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

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

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

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

6.00	C	MHHCC	0.00	MEM HOS OP SURG	40.00	6.00
7.00	B		0.00	MEMORIAL HOME O	100.00	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: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet A-8-1 Date/Time Prepared: 11/30/2021 2:40 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-527,749	0		1.00
2.00	6,943,981	9		2.00
3.00	22,991,782	0		3.00
4.00	20,650,003	0		4.00
4.01	4,853,306	0		4.01
4.02	1,697,053	0		4.02
4.03	1,753,238	0		4.03
4.04	3,815,782	0		4.04
4.05	0	0		4.05
5.00	62,177,396			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	SURGERY CENTER		6.00
7.00	HOME OFFICE		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: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-2 | Date/Time Prepared: 11/30/2021 2:40 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	947,068	0	947,068	197,500	7,061	1.00
2.00	40.00	SUBPROVIDER - IPF	324,916	324,916	0	181,300	0	2.00
3.00	41.00	SUBPROVIDER - IRF	33,296	33,296	0	179,000	0	3.00
4.00	50.00	OPERATING ROOM	43,334	43,334	0	246,400	0	4.00
5.00	53.00	ANESTHESIOLOGY	1,294,018	1,294,018	0	239,400	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	4,242,885	4,242,885	0	271,900	0	6.00
7.00	60.00	LABORATORY	150,000	150,000	0	271,900	0	7.00
8.00	65.00	RESPIRATORY THERAPY	9,938	9,938	0	211,500	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	694,923	694,923	0	211,500	0	9.00
10.00	90.00	CLINIC	371,576	371,576	0	211,500	0	10.00
11.00	90.04	HBURG URGENT CARE CLINIC	302,114	302,114	0	211,500	0	11.00
12.00	91.00	EMERGENCY	5,210,478	5,210,478	0	211,500	0	12.00
13.00	95.00	AMBULANCE SERVICES	1,206	1,206	0	21,500	0	13.00
200.00			13,625,752	12,678,684	947,068		7,061	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	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	670,456	33,523	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	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	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	90.00	CLINIC	0	0	0	0	0	10.00
11.00	90.04	HBURG URGENT CARE CLINIC	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	0	0	0	0	0	12.00
13.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	13.00
200.00			670,456	33,523	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	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	670,456	276,612	276,612		1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	324,916		2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	33,296		3.00
4.00	50.00	OPERATING ROOM	0	0	0	43,334		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	1,294,018		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	4,242,885		6.00
7.00	60.00	LABORATORY	0	0	0	150,000		7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	9,938		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	694,923		9.00
10.00	90.00	CLINIC	0	0	0	371,576		10.00
11.00	90.04	HBURG URGENT CARE CLINIC	0	0	0	302,114		11.00
12.00	91.00	EMERGENCY	0	0	0	5,210,478		12.00
13.00	95.00	AMBULANCE SERVICES	0	0	0	1,206		13.00
200.00			0	670,456	276,612	12,955,296		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	11,465,641	11,465,641				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,532,618		5,532,618			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	22,991,782	0	0	22,991,782		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,134,725	316,529	152,737	896,589	25,500,580	5.00
6.00	00600	MAINTENANCE & REPAIRS	8,580,591	15,942	7,693	128,222	8,732,448	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	365,727	36,334	17,533	71,162	490,756	8.00
9.00	00900	HOUSEKEEPING	1,697,053	0	0	0	1,697,053	9.00
10.00	01000	DIETARY	344,736	33,915	16,365	52,902	447,918	10.00
11.00	01100	CAFETERIA	684,518	113,464	54,751	197,026	1,049,759	11.00
13.00	01300	NURSING ADMINISTRATION	914,762	25,267	12,192	204,416	1,156,637	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	413,248	21,068	10,166	64,804	509,286	14.00
15.00	01500	PHARMACY	1,852,802	66,251	31,969	457,773	2,408,795	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,738,031	0	0	0	1,738,031	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	832,537	0	0	0	832,537	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	929,165	93,411	45,074	230,065	1,297,715	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,723,914	567,658	273,917	1,340,850	7,906,339	30.00
31.00	03100	INTENSIVE CARE UNIT	2,852,660	260,630	125,764	659,987	3,899,041	31.00
40.00	04000	SUBPROVIDER - IPF	1,374,121	205,897	99,353	394,752	2,074,123	40.00
41.00	04100	SUBPROVIDER - IRF	736,089	107,423	51,836	151,620	1,046,968	41.00
43.00	04300	NURSERY	616,339	67,404	32,525	132,790	849,058	43.00
44.00	04400	SKILLED NURSING FACILITY	1,331,502	116,823	56,372	308,143	1,812,840	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,577,962	773,919	373,446	1,148,565	15,873,892	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,232,677	134,808	65,050	265,580	1,698,115	52.00
53.00	05300	ANESTHESIOLOGY	527,794	0	0	981,020	1,508,814	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,417,253	260,267	125,589	1,549,552	5,352,661	54.00
56.00	05600	RADIOISOTOPE	712,139	17,684	8,533	41,629	779,985	56.00
60.00	06000	LABORATORY	7,537,293	125,609	60,611	626,699	8,350,212	60.00
65.00	06500	RESPIRATORY THERAPY	1,879,456	46,097	22,244	308,032	2,255,829	65.00
66.00	06600	PHYSICAL THERAPY	2,359,663	107,674	51,957	606,447	3,125,741	66.00
69.00	06900	ELECTROCARDIOLOGY	4,438,396	245,239	118,337	642,398	5,444,370	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	159,981	30,481	14,708	23,893	229,063	69.02
69.03	06903	SLEEP LAB	289,502	35,018	16,898	64,639	406,057	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,280,938	0	0	0	1,280,938	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,492,184	0	0	0	5,492,184	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,834,489	0	0	0	18,834,489	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	479,145	36,008	17,375	89,552	622,080	88.00
88.01	08801	RURAL HEALTH CLINIC II	527,149	83,071	40,085	107,828	758,133	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	643,977	106,683	51,479	107,350	909,489	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	3,130,132	211,662	102,135	549,703	3,993,632	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	1,174,300	100,066	48,286	323,681	1,646,333	90.04
90.05	09005	DIABETES MGMT CLINIC	66,650	10,327	4,983	15,636	97,596	90.05
91.00	09100	EMERGENCY	4,265,241	201,460	97,212	2,047,557	6,611,470	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,779,984	40,558	19,571	487,881	2,327,994	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	2,280,976	47,100	22,728	471,366	2,822,170	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	171,199,842	4,661,747	2,249,474	15,750,109	153,871,131	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,662	9,005	0	27,667	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32,938,800	1,915,377	924,244	6,697,691	42,476,112	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,035,615	46,148	22,268	240,102	1,344,133	192.01
194.00	07950	LODGE	15,322	541,376	261,235	1,105	819,038	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	99,414	18,875	9,108	22,808	150,205	194.02
194.03	07953	MKT/PHY SERVICES	4,076,556	1,504	726	49,296	4,128,082	194.03
194.04	07954	COMMUNITY EDUCATION	463,877	92,609	44,687	80,480	681,653	194.04

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.05	07955	VOLUNTEER	247,298	0	0	52,249	299,547	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	111,777	0	0	23,354	135,131	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	1,496,526	0	0	74,588	1,571,114	194.10
194.11	07961	HOME OFFICE	0	4,169,343	2,011,871	0	6,181,214	194.11
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)	211,685,027	11,465,641	5,532,618	22,991,782	211,685,027	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,500,580					5.00
6.00	00600	MAINTENANCE & REPAIRS	1,196,031	9,928,479				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	67,216	32,402	590,374			8.00
9.00	00900	HOUSEKEEPING	232,435	0	0	1,929,488		9.00
10.00	01000	DIETARY	61,349	30,245	4,427	5,897	549,836	10.00
11.00	01100	CAFETERIA	143,779	101,186	0	19,729	0	11.00
13.00	01300	NURSING ADMINISTRATION	158,418	22,533	0	4,393	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	69,754	18,789	21,677	3,663	0	14.00
15.00	01500	PHARMACY	329,918	59,082	0	11,520	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	238,048	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	114,028	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	177,740	83,303	0	16,242	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,082,884	506,234	116,461	98,703	217,994	30.00
31.00	03100	INTENSIVE CARE UNIT	534,028	232,428	45,336	45,318	103,164	31.00
40.00	04000	SUBPROVIDER - IPF	284,080	183,618	15,499	35,801	57,100	40.00
41.00	04100	SUBPROVIDER - IRF	143,397	95,799	11,865	18,678	27,643	41.00
43.00	04300	NURSERY	116,290	60,110	353	11,720	34,724	43.00
44.00	04400	SKILLED NURSING FACILITY	248,294	104,182	26,714	20,313	109,211	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,174,152	690,175	86,172	134,567	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	232,581	120,221	34,941	23,440	0	52.00
53.00	05300	ANESTHESIOLOGY	206,653	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	733,122	232,104	73,693	45,254	0	54.00
56.00	05600	RADIOISOTOPE	106,830	15,771	0	3,075	0	56.00
60.00	06000	LABORATORY	1,143,678	112,017	3,150	21,841	0	60.00
65.00	06500	RESPIRATORY THERAPY	308,967	41,109	0	8,015	0	65.00
66.00	06600	PHYSICAL THERAPY	428,114	96,023	14,157	18,722	0	66.00
69.00	06900	ELECTROCARDIOLOGY	745,683	218,702	36,792	42,642	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	31,373	27,183	174	5,300	0	69.02
69.03	06903	SLEEP LAB	55,615	31,229	3,511	6,089	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	175,442	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	752,231	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,579,647	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	85,203	32,112	0	6,261	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	103,837	74,082	0	14,444	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	124,567	95,140	1,229	18,550	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	546,984	188,759	12,268	36,803	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	225,488	89,238	1,205	17,399	0	90.04
90.05	09005	DIABETES MGMT CLINIC	13,367	9,210	0	1,796	0	90.05
91.00	09100	EMERGENCY	905,533	179,661	77,150	35,029	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	318,851	36,169	0	7,052	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	386,536	42,004	0	8,190	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,582,143	3,860,820	586,774	746,446	549,836	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,789	16,643	0	3,245	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,817,712	1,708,119	3,600	333,041	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	184,098	41,154	0	8,024	0	192.01
194.00	07950	LODGE	112,179	482,795	0	94,133	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	20,573	16,833	0	3,282	0	194.02
194.03	07953	MKT/PHY SERVICES	565,399	1,341	0	262	0	194.03
194.04	07954	COMMUNITY EDUCATION	93,362	82,588	0	16,103	0	194.04
194.05	07955	VOLUNTEER	41,027	0	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	18,508	0	0	0	0	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
194.10	07960	EMERGENCY PREPAREDNESS	215,186	0	0	0	0	194.10
194.11	07961	HOME OFFICE	846,604	3,718,186	0	724,952	0	194.11
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)	25,500,580	9,928,479	590,374	1,929,488	549,836	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I | Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,314,453					11.00
13.00	01300	NURSING ADMINISTRATION	14,832	1,356,813				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,800	0	631,969			14.00
15.00	01500	PHARMACY	31,862	0	3,201	2,844,378		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,976,079	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	6,804	0	170	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	102,501	373,110	15,891	0	39,352	30.00
31.00	03100	INTENSIVE CARE UNIT	54,608	198,776	4,608	0	26,237	31.00
40.00	04000	SUBPROVIDER - IPF	30,467	110,901	928	0	11,176	40.00
41.00	04100	SUBPROVIDER - IRF	10,878	39,598	341	0	4,529	41.00
43.00	04300	NURSERY	10,508	38,250	0	0	4,657	43.00
44.00	04400	SKILLED NURSING FACILITY	27,593	100,441	1,771	0	4,291	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	85,176	310,045	188,679	0	248,115	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,017	0	0	0	5,977	52.00
53.00	05300	ANESTHESIOLOGY	22,207	0	16,330	0	9,033	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	59,404	0	14,556	0	256,161	54.00
56.00	05600	RADIOISOTOPE	2,643	0	169	0	35,971	56.00
60.00	06000	LABORATORY	62,754	0	127,907	0	196,128	60.00
65.00	06500	RESPIRATORY THERAPY	29,513	0	23,502	0	20,953	65.00
66.00	06600	PHYSICAL THERAPY	50,253	0	2,003	0	38,783	66.00
69.00	06900	ELECTROCARDIOLOGY	37,929	0	103,392	0	136,318	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	2,259	0	223	0	3,338	69.02
69.03	06903	SLEEP LAB	6,416	0	548	0	5,447	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	63,467	0	26,120	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	53,154	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,844,378	384,494	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,456	0	365	0	2,977	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,128	0	541	0	3,121	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	10,334	0	4,115	0	14,947	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	51,014	185,692	7,419	0	59,521	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	23,357	0	1,872	0	11,675	90.04
90.05	09005	DIABETES MGMT CLINIC	1,359	0	83	0	396	90.05
91.00	09100	EMERGENCY	80,213	0	7,763	0	165,935	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	54,562	0	2,243	0	19,460	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	43,295	0	1,480	0	9,387	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	958,142	1,356,813	593,567	2,844,378	1,797,653	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	305,876	0	21,849	0	171,244	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	16,895	0	175	0	5,989	192.01
194.00	07950	LODGE	142	0	68	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	2,609	0	84	0	0	194.02
194.03	07953	MKT/PHY SERVICES	2,494	0	8	0	1,193	194.03
194.04	07954	COMMUNITY EDUCATION	12,009	0	1,081	0	0	194.04
194.05	07955	VOLUNTEER	4,174	0	114	0	0	194.05
194.06	07956	MAB	3,318	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	120	0	0	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	8,794	0	14,903	0	0	194.10
194.11	07961	HOME OFFICE	0	0	0	0	0	194.11
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)	1,314,453	1,356,813	631,969	2,844,378	1,976,079	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			21.00	22.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	946,565					21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD		1,581,974				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	309,749	517,681	11,286,899	-827,430	10,459,469	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	5,143,544	0	5,143,544	31.00
40.00	04000	SUBPROVIDER - IPF	52,908	88,423	2,945,024	-141,331	2,803,693	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	1,399,696	0	1,399,696	41.00
43.00	04300	NURSERY	0	0	1,125,670	0	1,125,670	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	2,455,650	0	2,455,650	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	116,397	194,531	20,101,901	-310,928	19,790,973	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	2,136,292	0	2,136,292	52.00
53.00	05300	ANESTHESIOLOGY	18,277	30,546	1,811,860	-48,823	1,763,037	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,783	51,446	6,849,184	-82,229	6,766,955	54.00
56.00	05600	RADIOISOTOPE	0	0	944,444	0	944,444	56.00
60.00	06000	LABORATORY	4,810	8,038	10,030,535	-12,848	10,017,687	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,687,888	0	2,687,888	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,773,796	0	3,773,796	66.00
69.00	06900	ELECTROCARDIOLOGY	24,049	40,192	6,830,069	-64,241	6,765,828	69.00
69.01	06901	PULMONARY	21,163	35,369	56,532	-56,532	0	69.01
69.02	06902	CARDIOPULMONARY	24,049	40,192	363,154	-64,241	298,913	69.02
69.03	06903	SLEEP LAB	0	0	514,912	0	514,912	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,545,967	0	1,545,967	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	6,297,569	0	6,297,569	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	24,643,008	0	24,643,008	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	755,454	0	755,454	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	963,286	0	963,286	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	1,178,371	0	1,178,371	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	5,082,092	0	5,082,092	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	23,087	38,585	2,078,239	-61,672	2,016,567	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	123,807	0	123,807	90.05
91.00	09100	EMERGENCY	41,364	69,131	8,173,249	-110,495	8,062,754	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	2,766,331	0	2,766,331	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	3,313,062	0	3,313,062	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE			0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	666,636	1,114,134	137,377,485	-1,780,770	135,596,715	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	51,344	0	51,344	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	254,918	426,040	51,518,511	-680,958	50,837,553	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	1,600,468	0	1,600,468	192.01
194.00	07950	LODGE	0	0	1,508,355	0	1,508,355	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	0	193,586	0	193,586	194.02
194.03	07953	MKT/PHY SERVICES	0	0	4,698,779	0	4,698,779	194.03
194.04	07954	COMMUNITY EDUCATION	0	0	886,796	0	886,796	194.04

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			21.00	22.00	24.00	25.00	26.00	
194.05	07955	VOLUNTEER	0	0	344,862	0	344,862	194.05
194.06	07956	MAB	0	0	3,318	0	3,318	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	153,759	0	153,759	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	0	1,809,997	0	1,809,997	194.10
194.11	07961	HOME OFFICE	25,011	41,800	11,537,767	-66,811	11,470,956	194.11
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	946,565	1,581,974	211,685,027	-2,528,539	209,156,488	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II | Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	316,529	152,737	469,266	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	15,942	7,693	23,635	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	36,334	17,533	53,867	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	33,915	16,365	50,280	0	10.00
11.00	01100	CAFETERIA	0	113,464	54,751	168,215	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	25,267	12,192	37,459	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,068	10,166	31,234	0	14.00
15.00	01500	PHARMACY	0	66,251	31,969	98,220	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	93,411	45,074	138,485	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	567,658	273,917	841,575	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	260,630	125,764	386,394	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	205,897	99,353	305,250	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	107,423	51,836	159,259	0	41.00
43.00	04300	NURSERY	0	67,404	32,525	99,929	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	116,823	56,372	173,195	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	773,919	373,446	1,147,365	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	134,808	65,050	199,858	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	260,267	125,589	385,856	0	54.00
56.00	05600	RADIOISOTOPE	0	17,684	8,533	26,217	0	56.00
60.00	06000	LABORATORY	0	125,609	60,611	186,220	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	46,097	22,244	68,341	0	65.00
66.00	06600	PHYSICAL THERAPY	0	107,674	51,957	159,631	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	245,239	118,337	363,576	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	30,481	14,708	45,189	0	69.02
69.03	06903	SLEEP LAB	0	35,018	16,898	51,916	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	36,008	17,375	53,383	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	83,071	40,085	123,156	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	106,683	51,479	158,162	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	211,662	102,135	313,797	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	100,066	48,286	148,352	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0	10,327	4,983	15,310	0	90.05
91.00	09100	EMERGENCY	0	201,460	97,212	298,672	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	40,558	19,571	60,129	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	47,100	22,728	69,828	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,661,747	2,249,474	6,911,221	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,662	9,005	27,667	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,915,377	924,244	2,839,621	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	46,148	22,268	68,416	0	192.01
194.00	07950	LODGE	0	541,376	261,235	802,611	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	18,875	9,108	27,983	0	194.02
194.03	07953	MKT/PHY SERVICES	0	1,504	726	2,230	0	194.03
194.04	07954	COMMUNITY EDUCATION	0	92,609	44,687	137,296	0	194.04
194.05	07955	VOLUNTEER	0	0	0	0	0	194.05

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	0	0	0	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	0	0	0	0	194.10
194.11	07961	HOME OFFICE	0	4,169,343	2,011,871	6,181,214	0	194.11
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	11,465,641	5,532,618	16,998,259	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	469,266					5.00
6.00	00600	MAINTENANCE & REPAIRS	22,006	45,641				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,237	149	55,253			8.00
9.00	00900	HOUSEKEEPING	4,277	0	0	4,277		9.00
10.00	01000	DIETARY	1,129	139	414	13	51,975	10.00
11.00	01100	CAFETERIA	2,645	465	0	44	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,915	104	0	10	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,283	86	2,029	8	0	14.00
15.00	01500	PHARMACY	6,070	272	0	26	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,380	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,098	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	3,270	383	0	36	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,924	2,327	10,900	219	20,606	30.00
31.00	03100	INTENSIVE CARE UNIT	9,826	1,068	4,243	100	9,752	31.00
40.00	04000	SUBPROVIDER - IPF	5,227	844	1,451	79	5,398	40.00
41.00	04100	SUBPROVIDER - IRF	2,638	440	1,110	41	2,613	41.00
43.00	04300	NURSERY	2,140	276	33	26	3,282	43.00
44.00	04400	SKILLED NURSING FACILITY	4,568	479	2,500	45	10,324	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,002	3,173	8,065	298	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,279	553	3,270	52	0	52.00
53.00	05300	ANESTHESIOLOGY	3,802	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,489	1,067	6,897	100	0	54.00
56.00	05600	RADIOISOTOPE	1,966	72	0	7	0	56.00
60.00	06000	LABORATORY	21,043	515	295	48	0	60.00
65.00	06500	RESPIRATORY THERAPY	5,685	189	0	18	0	65.00
66.00	06600	PHYSICAL THERAPY	7,877	441	1,325	42	0	66.00
69.00	06900	ELECTROCARDIOLOGY	13,720	1,005	3,443	95	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	577	125	16	12	0	69.02
69.03	06903	SLEEP LAB	1,023	144	329	13	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,228	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,840	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,463	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,568	148	0	14	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,910	341	0	32	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	2,292	437	115	41	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	10,064	868	1,148	82	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	4,149	410	113	39	0	90.04
90.05	09005	DIABETES MGMT CLINIC	246	42	0	4	0	90.05
91.00	09100	EMERGENCY	16,661	826	7,220	78	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,867	166	0	16	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	7,112	193	0	18	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	323,496	17,747	54,916	1,656	51,975	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	70	77	0	7	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	107,117	7,852	337	738	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,387	189	0	18	0	192.01
194.00	07950	LODGE	2,064	2,219	0	209	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	379	77	0	7	0	194.02
194.03	07953	MKT/PHY SERVICES	10,403	6	0	1	0	194.03
194.04	07954	COMMUNITY EDUCATION	1,718	380	0	36	0	194.04
194.05	07955	VOLUNTEER	755	0	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	341	0	0	0	0	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
194.10	07960	EMERGENCY PREPAREDNESS	3,959	0	0	0	0	194.10
194.11	07961	HOME OFFICE	15,577	17,094	0	1,605	0	194.11
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)	469,266	45,641	55,253	4,277	51,975	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	171,369					11.00
13.00	01300	NURSING ADMINISTRATION	1,934	42,422				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,147	0	35,787			14.00
15.00	01500	PHARMACY	4,154	0	181	108,923		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	4,380	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	887	0	10	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,363	11,666	900	0	83	30.00
31.00	03100	INTENSIVE CARE UNIT	7,119	6,215	261	0	56	31.00
40.00	04000	SUBPROVIDER - IPF	3,972	3,467	53	0	24	40.00
41.00	04100	SUBPROVIDER - IRF	1,418	1,238	19	0	10	41.00
43.00	04300	NURSERY	1,370	1,196	0	0	10	43.00
44.00	04400	SKILLED NURSING FACILITY	3,597	3,140	100	0	9	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,105	9,694	10,682	0	526	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,740	0	0	0	13	52.00
53.00	05300	ANESTHESIOLOGY	2,895	0	925	0	19	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,745	0	824	0	543	54.00
56.00	05600	RADIOISOTOPE	345	0	10	0	76	56.00
60.00	06000	LABORATORY	8,181	0	7,244	0	416	60.00
65.00	06500	RESPIRATORY THERAPY	3,848	0	1,331	0	44	65.00
66.00	06600	PHYSICAL THERAPY	6,552	0	113	0	82	66.00
69.00	06900	ELECTROCARDIOLOGY	4,945	0	5,855	0	289	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	295	0	13	0	7	69.02
69.03	06903	SLEEP LAB	837	0	31	0	12	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,594	0	55	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	113	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	108,923	1,004	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	842	0	21	0	6	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,190	0	31	0	7	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,347	0	233	0	32	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	6,651	5,806	420	0	126	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	3,045	0	106	0	25	90.04
90.05	09005	DIABETES MGMT CLINIC	177	0	5	0	1	90.05
91.00	09100	EMERGENCY	10,458	0	440	0	352	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,113	0	127	0	41	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	5,644	0	84	0	20	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	124,916	42,422	33,613	108,923	4,001	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,878	0	1,237	0	363	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,203	0	10	0	13	192.01
194.00	07950	LODGE	18	0	4	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	340	0	5	0	0	194.02
194.03	07953	MKT/PHY SERVICES	325	0	0	0	3	194.03
194.04	07954	COMMUNITY EDUCATION	1,566	0	61	0	0	194.04
194.05	07955	VOLUNTEER	544	0	6	0	0	194.05
194.06	07956	MAB	433	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	7	0	0	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	1,146	0	844	0	0	194.10
194.11	07961	HOME OFFICE	0	0	0	0	0	194.11
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)	171,369	42,422	35,787	108,923	4,380	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II | Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	INTERNS & RESIDENTS: SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS: SERVICES-OTHER PRGM. COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			21.00	22.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,098					21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD		143,071				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS			921,563	0	921,563	30.00
31.00	03100	INTENSIVE CARE UNIT			425,034	0	425,034	31.00
40.00	04000	SUBPROVIDER - IPF			325,765	0	325,765	40.00
41.00	04100	SUBPROVIDER - IRF			168,786	0	168,786	41.00
43.00	04300	NURSERY			108,262	0	108,262	43.00
44.00	04400	SKILLED NURSING FACILITY			197,957	0	197,957	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM			1,230,910	0	1,230,910	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM			210,765	0	210,765	52.00
53.00	05300	ANESTHESIOLOGY			7,641	0	7,641	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			416,521	0	416,521	54.00
56.00	05600	RADIOISOTOPE			28,693	0	28,693	56.00
60.00	06000	LABORATORY			223,962	0	223,962	60.00
65.00	06500	RESPIRATORY THERAPY			79,456	0	79,456	65.00
66.00	06600	PHYSICAL THERAPY			176,063	0	176,063	66.00
69.00	06900	ELECTROCARDIOLOGY			392,928	0	392,928	69.00
69.01	06901	PULMONARY			0	0	0	69.01
69.02	06902	CARDIOPULMONARY			46,234	0	46,234	69.02
69.03	06903	SLEEP LAB			54,305	0	54,305	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY			0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS			6,877	0	6,877	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			13,953	0	13,953	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			157,390	0	157,390	73.00
74.00	07400	RENAL DIALYSIS			0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC			55,982	0	55,982	88.00
88.01	08801	RURAL HEALTH CLINIC II			126,667	0	126,667	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	89.00
90.00	09000	CLINIC			162,659	0	162,659	90.00
90.01	09001	IMED			0	0	0	90.01
90.02	09002	ONCOLOGY			338,962	0	338,962	90.02
90.03	09003	OUTPATIENT CENTER			0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC			156,239	0	156,239	90.04
90.05	09005	DIABETES MGMT CLINIC			15,785	0	15,785	90.05
91.00	09100	EMERGENCY			334,707	0	334,707	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES			73,459	0	73,459	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED			0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY			82,899	0	82,899	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE			0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	6,540,424	0	6,540,424	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN			27,821	0	27,821	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES			2,997,143	0	2,997,143	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES			74,236	0	74,236	192.01
194.00	07950	LODGE			807,125	0	807,125	194.00
194.01	07951	OTHER NRCC			0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION			28,791	0	28,791	194.02
194.03	07953	MKT/PHY SERVICES			12,968	0	12,968	194.03
194.04	07954	COMMUNITY EDUCATION			141,057	0	141,057	194.04

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS				
			21.00	22.00	24.00	25.00	26.00	
194.05	07955	VOLUNTEER			1,305	0	1,305	194.05
194.06	07956	MAB			433	0	433	194.06
194.07	07957	OFFSITE COVID SCREENING			348	0	348	194.07
194.08	07958	PUBLIC RELATIONS			0	0	0	194.08
194.09	07959	UNUSED SPACE			0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS			5,949	0	5,949	194.10
194.11	07961	HOME OFFICE			6,215,490	0	6,215,490	194.11
200.00		Cross Foot Adjustments	2,098	143,071	145,169	0	145,169	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,098	143,071	16,998,259	0	16,998,259	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	914,814					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		914,814				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	95,021,508			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,255	25,255	3,705,465	-25,500,580	186,184,447	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,272	1,272	529,923	0	8,732,448	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,899	2,899	294,101	0	490,756	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	1,697,053	9.00
10.00	01000	DIETARY	2,706	2,706	218,637	0	447,918	10.00
11.00	01100	CAFETERIA	9,053	9,053	814,279	0	1,049,759	11.00
13.00	01300	NURSING ADMINISTRATION	2,016	2,016	844,819	0	1,156,637	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,681	1,681	267,825	0	509,286	14.00
15.00	01500	PHARMACY	5,286	5,286	1,891,904	0	2,408,795	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,738,031	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	832,537	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	7,453	7,453	950,822	0	1,297,715	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,292	45,292	5,541,526	0	7,906,339	30.00
31.00	03100	INTENSIVE CARE UNIT	20,795	20,795	2,727,623	0	3,899,041	31.00
40.00	04000	SUBPROVIDER - IPF	16,428	16,428	1,631,449	0	2,074,123	40.00
41.00	04100	SUBPROVIDER - IRF	8,571	8,571	626,622	0	1,046,968	41.00
43.00	04300	NURSERY	5,378	5,378	548,801	0	849,058	43.00
44.00	04400	SKILLED NURSING FACILITY	9,321	9,321	1,273,509	0	1,812,840	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	61,749	61,749	4,746,842	0	15,873,892	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,756	10,756	1,097,601	0	1,698,115	52.00
53.00	05300	ANESTHESIOLOGY	0	0	4,054,405	0	1,508,814	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,766	20,766	6,404,059	0	5,352,661	54.00
56.00	05600	RADIOISOTOPE	1,411	1,411	172,048	0	779,985	56.00
60.00	06000	LABORATORY	10,022	10,022	2,590,050	0	8,350,212	60.00
65.00	06500	RESPIRATORY THERAPY	3,678	3,678	1,273,050	0	2,255,829	65.00
66.00	06600	PHYSICAL THERAPY	8,591	8,591	2,506,352	0	3,125,741	66.00
69.00	06900	ELECTROCARDIOLOGY	19,567	19,567	2,654,934	0	5,444,370	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	2,432	2,432	98,746	0	229,063	69.02
69.03	06903	SLEEP LAB	2,794	2,794	267,144	0	406,057	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,280,938	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,492,184	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	18,834,489	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,873	2,873	370,106	0	622,080	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,628	6,628	445,636	0	758,133	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	8,512	8,512	443,660	0	909,489	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	16,888	16,888	2,271,837	0	3,993,632	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	7,984	7,984	1,337,723	0	1,646,333	90.04
90.05	09005	DIABETES MGMT CLINIC	824	824	64,622	0	97,596	90.05
91.00	09100	EMERGENCY	16,074	16,074	8,462,238	0	6,611,470	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,236	3,236	2,016,337	0	2,327,994	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	3,758	3,758	1,948,083	0	2,822,170	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	371,949	371,949	65,092,778	-25,500,580	128,370,551	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,489	1,489	0	0	27,667	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	152,823	152,823	27,680,536	0	42,476,112	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,682	3,682	992,305	0	1,344,133	192.01
194.00	07950	LODGE	43,195	43,195	4,565	0	819,038	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	1,506	1,506	94,264	0	150,205	194.02
194.03	07953	MKT/PHY SERVICES	120	120	203,733	0	4,128,082	194.03
194.04	07954	COMMUNITY EDUCATION	7,389	7,389	332,610	0	681,653	194.04

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
194.05	07955	VOLUNTEER	0	0	215,937	0	299,547	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	96,518	0	135,131	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	0	308,262	0	1,571,114	194.10
194.11	07961	HOME OFFICE	332,661	332,661	0	0	6,181,214	194.11
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)	11,465,641	5,532,618	22,991,782		25,500,580	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.533303	6.047806	0.241964		0.136964	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		469,266	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.002520	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: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
			6.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	888,287					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,899	853,309				8.00
9.00	00900	HOUSEKEEPING	0	0	885,388			9.00
10.00	01000	DIETARY	2,706	6,399	2,706	21,820		10.00
11.00	01100	CAFETERIA	9,053	0	9,053	0	2,024,180	11.00
13.00	01300	NURSING ADMINISTRATION	2,016	0	2,016	0	22,841	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,681	31,332	1,681	0	13,552	14.00
15.00	01500	PHARMACY	5,286	0	5,286	0	49,065	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	7,453	0	7,453	0	10,477	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,292	168,329	45,292	8,651	157,846	30.00
31.00	03100	INTENSIVE CARE UNIT	20,795	65,528	20,795	4,094	84,093	31.00
40.00	04000	SUBPROVIDER - IPF	16,428	22,402	16,428	2,266	46,917	40.00
41.00	04100	SUBPROVIDER - IRF	8,571	17,149	8,571	1,097	16,752	41.00
43.00	04300	NURSERY	5,378	510	5,378	1,378	16,182	43.00
44.00	04400	SKILLED NURSING FACILITY	9,321	38,612	9,321	4,334	42,492	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	61,749	124,551	61,749	0	131,166	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,756	50,502	10,756	0	32,365	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	34,197	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,766	106,514	20,766	0	91,479	54.00
56.00	05600	RADIOISOTOPE	1,411	0	1,411	0	4,070	56.00
60.00	06000	LABORATORY	10,022	4,553	10,022	0	96,637	60.00
65.00	06500	RESPIRATORY THERAPY	3,678	0	3,678	0	45,448	65.00
66.00	06600	PHYSICAL THERAPY	8,591	20,462	8,591	0	77,386	66.00
69.00	06900	ELECTROCARDIOLOGY	19,567	53,178	19,567	0	58,408	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	2,432	251	2,432	0	3,479	69.02
69.03	06903	SLEEP LAB	2,794	5,074	2,794	0	9,881	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,873	0	2,873	0	9,942	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,628	0	6,628	0	14,056	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	8,512	1,776	8,512	0	15,914	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	16,888	17,732	16,888	0	78,558	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	7,984	1,741	7,984	0	35,968	90.04
90.05	09005	DIABETES MGMT CLINIC	824	0	824	0	2,093	90.05
91.00	09100	EMERGENCY	16,074	111,511	16,074	0	123,523	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,236	0	3,236	0	84,022	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	3,758	0	3,758	0	66,671	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	345,422	848,106	342,523	21,820	1,475,480	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,489	0	1,489	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	152,823	5,203	152,823	0	471,034	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,682	0	3,682	0	26,018	192.01
194.00	07950	LODGE	43,195	0	43,195	0	218	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	1,506	0	1,506	0	4,017	194.02
194.03	07953	MKT/PHY SERVICES	120	0	120	0	3,840	194.03
194.04	07954	COMMUNITY EDUCATION	7,389	0	7,389	0	18,493	194.04
194.05	07955	VOLUNTEER	0	0	0	0	6,428	194.05
194.06	07956	MAB	0	0	0	0	5,110	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	0	0	0	194.07

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
			6.00	8.00	9.00	10.00	11.00	
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	0	0	0	13,542	194.10
194.11	07961	HOME OFFICE	332,661	0	332,661	0	0	194.11
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)	9,928,479	590,374	1,929,488	549,836	1,314,453	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.177107	0.691864	2.179257	25.198717	0.649376	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	45,641	55,253	4,277	51,975	171,369	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.051381	0.064751	0.004831	2.381989	0.084661	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: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	574,006					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,755,054				14.00
15.00	01500	PHARMACY	0	64,611	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	598,115,385		16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	984	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	3,427	0	0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	157,846	320,732	0	11,910,283	322	30.00
31.00	03100	INTENSIVE CARE UNIT	84,093	93,001	0	7,941,129	0	31.00
40.00	04000	SUBPROVIDER - IPF	46,917	18,722	0	3,382,465	55	40.00
41.00	04100	SUBPROVIDER - IRF	16,752	6,890	0	1,370,806	0	41.00
43.00	04300	NURSERY	16,182	0	0	1,409,500	0	43.00
44.00	04400	SKILLED NURSING FACILITY	42,492	35,752	0	1,298,700	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	131,166	3,808,181	0	75,095,454	121	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,808,890	0	52.00
53.00	05300	ANESTHESIOLOGY	0	329,592	0	2,733,851	19	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	293,786	0	77,530,583	32	54.00
56.00	05600	RADIOISOTOPE	0	3,420	0	10,887,205	0	56.00
60.00	06000	LABORATORY	0	2,581,530	0	59,360,841	5	60.00
65.00	06500	RESPIRATORY THERAPY	0	474,345	0	6,341,706	0	65.00
66.00	06600	PHYSICAL THERAPY	0	40,419	0	11,738,185	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,086,741	0	41,258,413	25	69.00
69.01	06901	PULMONARY	0	0	0	0	22	69.01
69.02	06902	CARDIOPULMONARY	0	4,492	0	1,010,274	25	69.02
69.03	06903	SLEEP LAB	0	11,053	0	1,648,499	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,280,938	0	7,905,672	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,087,897	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	116,401,037	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,372	0	901,163	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	10,926	0	944,524	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	83,057	0	4,523,761	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	78,558	149,730	0	18,014,816	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	37,783	0	3,533,679	24	90.04
90.05	09005	DIABETES MGMT CLINIC	0	1,674	0	119,763	0	90.05
91.00	09100	EMERGENCY	0	156,671	0	50,222,599	43	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	45,268	0	5,889,690	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	29,872	0	2,841,026	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	574,006	11,979,985	100	544,112,411	693	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	440,981	0	51,829,292	265	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	3,535	0	1,812,666	0	192.01
194.00	07950	LODGE	0	1,366	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	1,705	0	0	0	194.02
194.03	07953	MKT/PHY SERVICES	0	164	0	361,016	0	194.03
194.04	07954	COMMUNITY EDUCATION	0	21,817	0	0	0	194.04

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	21.00	
194.05	07955	VOLUNTEER	0	2,291	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	2,430	0	0	0	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	300,780	0	0	0	194.10
194.11	07961	HOME OFFICE	0	0	0	0	26	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,356,813	631,969	2,844,378	1,976,079	946,565	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.363761	0.049547	28,443.780000	0.003304	961.956301	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	42,422	35,787	108,923	4,380	2,098	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.073905	0.002806	1,089.230000	0.000007	2.132114	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: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
			22.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	984		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	322		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
40.00	04000	SUBPROVIDER - IPF	55		40.00
41.00	04100	SUBPROVIDER - IRF	0		41.00
43.00	04300	NURSERY	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	121		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	19		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32		54.00
56.00	05600	RADIOISOTOPE	0		56.00
60.00	06000	LABORATORY	5		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
69.00	06900	ELECTROCARDIOLOGY	25		69.00
69.01	06901	PULMONARY	22		69.01
69.02	06902	CARDIOPULMONARY	25		69.02
69.03	06903	SLEEP LAB	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
74.00	07400	RENAL DIALYSIS	0		74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		89.00
90.00	09000	CLINIC	0		90.00
90.01	09001	IMED	0		90.01
90.02	09002	ONCOLOGY	0		90.02
90.03	09003	OUTPATIENT CENTER	0		90.03
90.04	09004	HBURG URGENT CARE CLINIC	24		90.04
90.05	09005	DIABETES MGMT CLINIC	0		90.05
91.00	09100	EMERGENCY	43		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		96.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	693		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	265		192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		192.01
194.00	07950	LODGE	0		194.00
194.01	07951	OTHER NRCC	0		194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0		194.02
194.03	07953	MKT/PHY SERVICES	0		194.03
194.04	07954	COMMUNITY EDUCATION	0		194.04
194.05	07955	VOLUNTEER	0		194.05

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/30/2021 2:40 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
			22.00		
194.06	07956	MAB	0		194.06
194.07	07957	OFFSITE COVID SCREENING	0		194.07
194.08	07958	PUBLIC RELATIONS	0		194.08
194.09	07959	UNUSED SPACE	0		194.09
194.10	07960	EMERGENCY PREPAREDNESS	0		194.10
194.11	07961	HOME OFFICE	26		194.11
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,581,974		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,607.697154		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	143,071		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	145.397358		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: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/30/2021 2:40 pm

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	10,459,469		10,459,469	0	10,459,469	30.00
31.00	03100	INTENSIVE CARE UNIT	5,143,544		5,143,544	0	5,143,544	31.00
40.00	04000	SUBPROVIDER - IPF	2,803,693		2,803,693	0	2,803,693	40.00
41.00	04100	SUBPROVIDER - IRF	1,399,696		1,399,696	0	1,399,696	41.00
43.00	04300	NURSERY	1,125,670		1,125,670	0	1,125,670	43.00
44.00	04400	SKILLED NURSING FACILITY	2,455,650		2,455,650	0	2,455,650	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,790,973		19,790,973	0	19,790,973	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,136,292		2,136,292	0	2,136,292	52.00
53.00	05300	ANESTHESIOLOGY	1,763,037		1,763,037	0	1,763,037	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,766,955		6,766,955	0	6,766,955	54.00
56.00	05600	RADIOISOTOPE	944,444		944,444	0	944,444	56.00
60.00	06000	LABORATORY	10,017,687		10,017,687	0	10,017,687	60.00
65.00	06500	RESPIRATORY THERAPY	2,687,888	0	2,687,888	0	2,687,888	65.00
66.00	06600	PHYSICAL THERAPY	3,773,796	0	3,773,796	0	3,773,796	66.00
69.00	06900	ELECTROCARDIOLOGY	6,765,828		6,765,828	0	6,765,828	69.00
69.01	06901	PULMONARY	0		0	0	0	69.01
69.02	06902	CARDIOPULMONARY	298,913		298,913	0	298,913	69.02
69.03	06903	SLEEP LAB	514,912		514,912	0	514,912	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,545,967		1,545,967	0	1,545,967	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,297,569		6,297,569	0	6,297,569	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,643,008		24,643,008	0	24,643,008	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	755,454		755,454	0	755,454	88.00
88.01	08801	RURAL HEALTH CLINIC II	963,286		963,286	0	963,286	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,178,371		1,178,371	0	1,178,371	90.00
90.01	09001	IMED	0		0	0	0	90.01
90.02	09002	ONCOLOGY	5,082,092		5,082,092	0	5,082,092	90.02
90.03	09003	OUTPATIENT CENTER	0		0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	2,016,567		2,016,567	0	2,016,567	90.04
90.05	09005	DIABETES MGMT CLINIC	123,807		123,807	0	123,807	90.05
91.00	09100	EMERGENCY	8,062,754		8,062,754	0	8,062,754	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,449,826		2,449,826		2,449,826	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,766,331		2,766,331	0	2,766,331	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	3,313,062		3,313,062		3,313,062	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	138,046,541	0	138,046,541	0	138,046,541	200.00
201.00		Less Observation Beds	2,449,826		2,449,826		2,449,826	201.00
202.00		Total (see instructions)	135,596,715	0	135,596,715	0	135,596,715	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I | Date/Time Prepared: 11/30/2021 2:40 pm

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	11,910,283		11,910,283			30.00
31.00	03100	INTENSIVE CARE UNIT	7,941,129		7,941,129			31.00
40.00	04000	SUBPROVIDER - IPF	3,382,465		3,382,465			40.00
41.00	04100	SUBPROVIDER - IRF	1,370,806		1,370,806			41.00
43.00	04300	NURSERY	1,409,500		1,409,500			43.00
44.00	04400	SKILLED NURSING FACILITY	1,298,700		1,298,700			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,612,599	65,482,855	75,095,454	0.263544	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,804,829	4,061	1,808,890	1.180996	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	745,635	1,988,216	2,733,851	0.644891	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,247,234	68,283,349	77,530,583	0.087281	0.000000	54.00
56.00	05600	RADIOISOTOPE	314,264	10,572,941	10,887,205	0.086748	0.000000	56.00
60.00	06000	LABORATORY	10,383,123	48,977,718	59,360,841	0.168759	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,499,693	4,842,013	6,341,706	0.423843	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,754,158	5,984,027	11,738,185	0.321497	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	12,251,873	29,006,540	41,258,413	0.163987	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0.000000	0.000000	69.01
69.02	06902	CARDIOPULMONARY	652	1,009,622	1,010,274	0.295873	0.000000	69.02
69.03	06903	SLEEP LAB	0	1,648,499	1,648,499	0.312352	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,299,598	5,606,074	7,905,672	0.195552	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,429,577	9,658,320	16,087,897	0.391448	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,087,426	87,313,611	116,401,037	0.211708	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	901,163	901,163			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	944,524	944,524			88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	93,777	4,429,984	4,523,761	0.260485	0.000000	90.00
90.01	09001	IMED	0	0	0	0.000000	0.000000	90.01
90.02	09002	ONCOLOGY	172,475	17,842,341	18,014,816	0.282106	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0.000000	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	5,092	3,528,587	3,533,679	0.570671	0.000000	90.04
90.05	09005	DIABETES MGMT CLINIC	0	119,763	119,763	1.033767	0.000000	90.05
91.00	09100	EMERGENCY	8,700,478	41,522,121	50,222,599	0.160540	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	395,231	5,345,521	5,740,752	0.426743	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,342,119	4,547,571	5,889,690	0.469690	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	2,841,026	2,841,026			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	127,452,716	422,400,447	549,853,163			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	127,452,716	422,400,447	549,853,163			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/30/2021 2:40 pm

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
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.263544	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.180996	52.00
53.00	05300	ANESTHESIOLOGY	0.644891	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087281	54.00
56.00	05600	RADIOISOTOPE	0.086748	56.00
60.00	06000	LABORATORY	0.168759	60.00
65.00	06500	RESPIRATORY THERAPY	0.423843	65.00
66.00	06600	PHYSICAL THERAPY	0.321497	66.00
69.00	06900	ELECTROCARDIOLOGY	0.163987	69.00
69.01	06901	PULMONARY	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0.295873	69.02
69.03	06903	SLEEP LAB	0.312352	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.195552	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.391448	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211708	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
90.00	09000	CLINIC	0.260485	90.00
90.01	09001	IMED	0.000000	90.01
90.02	09002	ONCOLOGY	0.282106	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.570671	90.04
90.05	09005	DIABETES MGMT CLINIC	1.033767	90.05
91.00	09100	EMERGENCY	0.160540	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.426743	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.469690	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/30/2021 2:40 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,459,469		10,459,469	0	10,459,469	30.00
31.00	03100	INTENSIVE CARE UNIT	5,143,544		5,143,544	0	5,143,544	31.00
40.00	04000	SUBPROVIDER - IPF	2,803,693		2,803,693	0	2,803,693	40.00
41.00	04100	SUBPROVIDER - IRF	1,399,696		1,399,696	0	1,399,696	41.00
43.00	04300	NURSERY	1,125,670		1,125,670	0	1,125,670	43.00
44.00	04400	SKILLED NURSING FACILITY	2,455,650		2,455,650	0	2,455,650	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,790,973		19,790,973	0	19,790,973	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,136,292		2,136,292	0	2,136,292	52.00
53.00	05300	ANESTHESIOLOGY	1,763,037		1,763,037	0	1,763,037	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,766,955		6,766,955	0	6,766,955	54.00
56.00	05600	RADIOISOTOPE	944,444		944,444	0	944,444	56.00
60.00	06000	LABORATORY	10,017,687		10,017,687	0	10,017,687	60.00
65.00	06500	RESPIRATORY THERAPY	2,687,888	0	2,687,888	0	2,687,888	65.00
66.00	06600	PHYSICAL THERAPY	3,773,796	0	3,773,796	0	3,773,796	66.00
69.00	06900	ELECTROCARDIOLOGY	6,765,828		6,765,828	0	6,765,828	69.00
69.01	06901	PULMONARY	0		0	0	0	69.01
69.02	06902	CARDIOPULMONARY	298,913		298,913	0	298,913	69.02
69.03	06903	SLEEP LAB	514,912		514,912	0	514,912	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,545,967		1,545,967	0	1,545,967	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,297,569		6,297,569	0	6,297,569	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,643,008		24,643,008	0	24,643,008	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	755,454		755,454	0	755,454	88.00
88.01	08801	RURAL HEALTH CLINIC II	963,286		963,286	0	963,286	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,178,371		1,178,371	0	1,178,371	90.00
90.01	09001	IMED	0		0	0	0	90.01
90.02	09002	ONCOLOGY	5,082,092		5,082,092	0	5,082,092	90.02
90.03	09003	OUTPATIENT CENTER	0		0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	2,016,567		2,016,567	0	2,016,567	90.04
90.05	09005	DIABETES MGMT CLINIC	123,807		123,807	0	123,807	90.05
91.00	09100	EMERGENCY	8,062,754		8,062,754	0	8,062,754	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,449,826		2,449,826		2,449,826	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,766,331		2,766,331	0	2,766,331	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	3,313,062		3,313,062		3,313,062	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	138,046,541	0	138,046,541	0	138,046,541	200.00
201.00		Less Observation Beds	2,449,826		2,449,826		2,449,826	201.00
202.00		Total (see instructions)	135,596,715	0	135,596,715	0	135,596,715	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/30/2021 2:40 pm

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	11,910,283		11,910,283			30.00
31.00	03100	INTENSIVE CARE UNIT	7,941,129		7,941,129			31.00
40.00	04000	SUBPROVIDER - IPF	3,382,465		3,382,465			40.00
41.00	04100	SUBPROVIDER - IRF	1,370,806		1,370,806			41.00
43.00	04300	NURSERY	1,409,500		1,409,500			43.00
44.00	04400	SKILLED NURSING FACILITY	1,298,700		1,298,700			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,612,599	65,482,855	75,095,454	0.263544	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,804,829	4,061	1,808,890	1.180996	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	745,635	1,988,216	2,733,851	0.644891	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,247,234	68,283,349	77,530,583	0.087281	0.000000	54.00
56.00	05600	RADIOISOTOPE	314,264	10,572,941	10,887,205	0.086748	0.000000	56.00
60.00	06000	LABORATORY	10,383,123	48,977,718	59,360,841	0.168759	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,499,693	4,842,013	6,341,706	0.423843	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,754,158	5,984,027	11,738,185	0.321497	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	12,251,873	29,006,540	41,258,413	0.163987	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0.000000	0.000000	69.01
69.02	06902	CARDIOPULMONARY	652	1,009,622	1,010,274	0.295873	0.000000	69.02
69.03	06903	SLEEP LAB	0	1,648,499	1,648,499	0.312352	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,299,598	5,606,074	7,905,672	0.195552	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,429,577	9,658,320	16,087,897	0.391448	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,087,426	87,313,611	116,401,037	0.211708	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	901,163	901,163	0.838310	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	944,524	944,524	1.019864	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	93,777	4,429,984	4,523,761	0.260485	0.000000	90.00
90.01	09001	IMED	0	0	0	0.000000	0.000000	90.01
90.02	09002	ONCOLOGY	172,475	17,842,341	18,014,816	0.282106	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0.000000	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	5,092	3,528,587	3,533,679	0.570671	0.000000	90.04
90.05	09005	DIABETES MGMT CLINIC	0	119,763	119,763	1.033767	0.000000	90.05
91.00	09100	EMERGENCY	8,700,478	41,522,121	50,222,599	0.160540	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	395,231	5,345,521	5,740,752	0.426743	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,342,119	4,547,571	5,889,690	0.469690	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	2,841,026	2,841,026			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	127,452,716	422,400,447	549,853,163			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	127,452,716	422,400,447	549,853,163			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/30/2021 2:40 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	PULMONARY	0.000000		69.01
69.02	06902	CARDIOPULMONARY	0.000000		69.02
69.03	06903	SLEEP LAB	0.000000		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	IMED	0.000000		90.01
90.02	09002	ONCOLOGY	0.000000		90.02
90.03	09003	OUTPATIENT CENTER	0.000000		90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.000000		90.04
90.05	09005	DIABETES MGMT CLINIC	0.000000		90.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part I Date/Time Prepared: 11/30/2021 2:40 pm

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	921,563	0	921,563	11,297	81.58	30.00
31.00	INTENSIVE CARE UNIT	425,034		425,034	4,094	103.82	31.00
40.00	SUBPROVIDER - IPF	325,765	0	325,765	2,266	143.76	40.00
41.00	SUBPROVIDER - IRF	168,786	0	168,786	1,097	153.86	41.00
43.00	NURSERY	108,262		108,262	1,378	78.56	43.00
44.00	SKILLED NURSING FACILITY	197,957		197,957	4,334	45.68	44.00
200.00	Total (lines 30 through 199)	2,147,367		2,147,367	24,466		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	3,624	295,646	30.00
31.00	INTENSIVE CARE UNIT	1,924	199,750	31.00
40.00	SUBPROVIDER - IPF	884	127,084	40.00
41.00	SUBPROVIDER - IRF	517	79,546	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	3,459	158,007	44.00
200.00	Total (lines 30 through 199)	10,408	860,033	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part II Date/Time Prepared: 11/30/2021 2:40 pm

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		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	1,230,910	75,095,454	0.016391	4,495,668	73,688	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	210,765	1,808,890	0.116516	0	0	52.00
53.00	05300	ANESTHESIOLOGY	7,641	2,733,851	0.002795	242,908	679	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	416,521	77,530,583	0.005372	5,628,186	30,235	54.00
56.00	05600	RADIOISOTOPE	28,693	10,887,205	0.002635	171,597	452	56.00
60.00	06000	LABORATORY	223,962	59,360,841	0.003773	4,486,762	16,929	60.00
65.00	06500	RESPIRATORY THERAPY	79,456	6,341,706	0.012529	659,666	8,265	65.00
66.00	06600	PHYSICAL THERAPY	176,063	11,738,185	0.014999	1,361,411	20,420	66.00
69.00	06900	ELECTROCARDIOLOGY	392,928	41,258,413	0.009524	6,103,254	58,127	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	46,234	1,010,274	0.045764	326	15	69.02
69.03	06903	SLEEP LAB	54,305	1,648,499	0.032942	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,877	7,905,672	0.000870	1,272,117	1,107	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,953	16,087,897	0.000867	3,694,845	3,203	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	157,390	116,401,037	0.001352	12,036,406	16,273	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	55,982	901,163	0.062122	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	126,667	944,524	0.134107	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	162,659	4,523,761	0.035957	48,375	1,739	90.00
90.01	09001	IMED	0	0	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	338,962	18,014,816	0.018816	47,004	884	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	156,239	3,533,679	0.044214	3,134	139	90.04
90.05	09005	DIABETES MGMT CLINIC	15,785	119,763	0.131802	0	0	90.05
91.00	09100	EMERGENCY	334,707	50,222,599	0.006664	4,441,609	29,599	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	215,849	5,740,752	0.037599	367,376	13,813	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50 through 199)	4,452,548	513,809,564		45,060,644	275,567	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part III Date/Time Prepared: 11/30/2021 2:40 pm

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		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
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	11,297	0.00	3,624	30.00
31.00	03100	INTENSIVE CARE UNIT		0	4,094	0.00	1,924	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	2,266	0.00	884	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	1,097	0.00	517	41.00
43.00	04300	NURSERY		0	1,378	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	4,334	0.00	3,459	44.00
200.00		Total (lines 30 through 199)		0	24,466		10,408	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
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/30/2021 2:40 pm

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		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	75,095,454	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,808,890	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,733,851	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	77,530,583	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	10,887,205	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	59,360,841	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,341,706	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,738,185	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	41,258,413	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	1,010,274	0.000000	69.02
69.03	06903	SLEEP LAB	0	0	0	1,648,499	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7,905,672	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,087,897	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	116,401,037	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	901,163	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	944,524	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	4,523,761	0.000000	90.00
90.01	09001	IMED	0	0	0	0	0.000000	90.01
90.02	09002	ONCOLOGY	0	0	0	18,014,816	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	3,533,679	0.000000	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	119,763	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	50,222,599	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,740,752	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
200.00		Total (lines 50 through 199)	0	0	0	513,809,564		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/30/2021 2:40 pm

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		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	4,495,668	0	17,992,276	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	242,908	0	680,171	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	5,628,186	0	20,776,257	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	171,597	0	4,843,357	0	56.00
60.00	06000	LABORATORY	0.000000	4,486,762	0	6,688,531	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	659,666	0	637,707	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,361,411	0	156,876	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	6,103,254	0	12,382,058	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.000000	326	0	635,700	0	69.02
69.03	06903	SLEEP LAB	0.000000	0	0	475,345	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,272,117	0	1,866,765	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,694,845	0	4,428,860	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	12,036,406	0	40,896,156	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	48,375	0	1,703,078	0	90.00
90.01	09001	IMED	0.000000	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.000000	47,004	0	7,582,620	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.000000	3,134	0	280,333	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	4,441,609	0	10,754,696	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	367,376	0	755,022	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		45,060,644	0	133,535,808	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/30/2021 2:40 pm

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		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	0.263544	17,992,276	0	0	4,741,756	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.180996	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.644891	680,171	0	0	438,636	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087281	20,776,257	0	0	1,813,372	54.00
56.00	05600	RADIOISOTOPE	0.086748	4,843,357	0	0	420,152	56.00
60.00	06000	LABORATORY	0.168759	6,688,531	0	0	1,128,750	60.00
65.00	06500	RESPIRATORY THERAPY	0.423843	637,707	0	0	270,288	65.00
66.00	06600	PHYSICAL THERAPY	0.321497	156,876	0	0	50,435	66.00
69.00	06900	ELECTROCARDIOLOGY	0.163987	12,382,058	0	0	2,030,497	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.295873	635,700	0	0	188,086	69.02
69.03	06903	SLEEP LAB	0.312352	475,345	0	0	148,475	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.195552	1,866,765	0	0	365,050	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.391448	4,428,860	0	0	1,733,668	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211708	40,896,156	0	57,831	8,658,043	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.260485	1,703,078	0	0	443,626	90.00
90.01	09001	IMED	0.000000	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.282106	7,582,620	0	0	2,139,103	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.570671	280,333	0	0	159,978	90.04
90.05	09005	DIABETES MGMT CLINIC	1.033767	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.160540	10,754,696	0	101	1,726,559	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.426743	755,022	0	0	322,200	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.469690		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		133,535,808	0	57,932	26,778,674	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		133,535,808	0	57,932	26,778,674	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/30/2021 2:40 pm

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
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
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	PULMONARY	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	69.02
69.03	06903	SLEEP LAB	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,243	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	IMED	0	0	90.01
90.02	09002	ONCOLOGY	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	90.05
91.00	09100	EMERGENCY	0	16	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	0	12,259	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	12,259	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part II Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Subprovider - IPF | 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	1,230,910	75,095,454	0.016391	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	210,765	1,808,890	0.116516	0	0	52.00
53.00	05300	ANESTHESIOLOGY	7,641	2,733,851	0.002795	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	416,521	77,530,583	0.005372	116,604	626	54.00
56.00	05600	RADIOISOTOPE	28,693	10,887,205	0.002635	0	0	56.00
60.00	06000	LABORATORY	223,962	59,360,841	0.003773	245,860	928	60.00
65.00	06500	RESPIRATORY THERAPY	79,456	6,341,706	0.012529	468	6	65.00
66.00	06600	PHYSICAL THERAPY	176,063	11,738,185	0.014999	20,786	312	66.00
69.00	06900	ELECTROCARDIOLOGY	392,928	41,258,413	0.009524	25,089	239	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	46,234	1,010,274	0.045764	0	0	69.02
69.03	06903	SLEEP LAB	54,305	1,648,499	0.032942	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,877	7,905,672	0.000870	370	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,953	16,087,897	0.000867	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	157,390	116,401,037	0.001352	294,922	399	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	55,982	901,163	0.062122	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	126,667	944,524	0.134107	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	162,659	4,523,761	0.035957	0	0	90.00
90.01	09001	IMED	0	0	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	338,962	18,014,816	0.018816	160	3	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	156,239	3,533,679	0.044214	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	15,785	119,763	0.131802	0	0	90.05
91.00	09100	EMERGENCY	334,707	50,222,599	0.006664	228,526	1,523	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,740,752	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50 through 199)	4,236,699	513,809,564		932,785	4,036	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Subprovider - IPF | 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	75,095,454	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,808,890	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,733,851	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	77,530,583	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	10,887,205	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	59,360,841	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,341,706	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,738,185	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	41,258,413	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	1,010,274	0.000000	69.02
69.03	06903	SLEEP LAB	0	0	0	1,648,499	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7,905,672	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,087,897	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	116,401,037	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	901,163	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	944,524	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	4,523,761	0.000000	90.00
90.01	09001	IMED	0	0	0	0	0.000000	90.01
90.02	09002	ONCOLOGY	0	0	0	18,014,816	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	3,533,679	0.000000	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	119,763	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	50,222,599	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,740,752	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
200.00		Total (lines 50 through 199)	0	0	0	513,809,564		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Subprovider - IPF | 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	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	116,604	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	245,860	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	468	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	20,786	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	25,089	0	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.000000	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0.000000	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	370	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	294,922	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	IMED	0.000000	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.000000	160	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	228,526	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		932,785	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part II Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Subprovider - IRF | 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	1,230,910	75,095,454	0.016391	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	210,765	1,808,890	0.116516	0	0	52.00
53.00	05300	ANESTHESIOLOGY	7,641	2,733,851	0.002795	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	416,521	77,530,583	0.005372	15,591	84	54.00
56.00	05600	RADIOISOTOPE	28,693	10,887,205	0.002635	0	0	56.00
60.00	06000	LABORATORY	223,962	59,360,841	0.003773	34,067	129	60.00
65.00	06500	RESPIRATORY THERAPY	79,456	6,341,706	0.012529	568	7	65.00
66.00	06600	PHYSICAL THERAPY	176,063	11,738,185	0.014999	666,545	9,998	66.00
69.00	06900	ELECTROCARDIOLOGY	392,928	41,258,413	0.009524	3,046	29	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	46,234	1,010,274	0.045764	0	0	69.02
69.03	06903	SLEEP LAB	54,305	1,648,499	0.032942	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,877	7,905,672	0.000870	1,369	1	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,953	16,087,897	0.000867	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	157,390	116,401,037	0.001352	126,590	171	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	55,982	901,163	0.062122	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	126,667	944,524	0.134107	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	162,659	4,523,761	0.035957	0	0	90.00
90.01	09001	IMED	0	0	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	338,962	18,014,816	0.018816	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	156,239	3,533,679	0.044214	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	15,785	119,763	0.131802	0	0	90.05
91.00	09100	EMERGENCY	334,707	50,222,599	0.006664	1,300	9	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,740,752	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50 through 199)	4,236,699	513,809,564		849,076	10,428	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Subprovider - IRF | 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	75,095,454	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,808,890	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,733,851	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	77,530,583	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	10,887,205	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	59,360,841	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,341,706	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,738,185	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	41,258,413	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	1,010,274	0.000000	69.02
69.03	06903	SLEEP LAB	0	0	0	1,648,499	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7,905,672	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,087,897	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	116,401,037	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	901,163	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	944,524	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	4,523,761	0.000000	90.00
90.01	09001	IMED	0	0	0	0	0.000000	90.01
90.02	09002	ONCOLOGY	0	0	0	18,014,816	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	3,533,679	0.000000	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	119,763	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	50,222,599	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,740,752	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
200.00		Total (lines 50 through 199)	0	0	0	513,809,564		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Subprovider - IRF | 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	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	15,591	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	34,067	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	568	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	666,545	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,046	0	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.000000	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0.000000	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,369	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	126,590	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	IMED	0.000000	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.000000	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	1,300	0	219	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		849,076	0	219	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Subprovider - IRF | 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	0.263544	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.180996	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.644891	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087281	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.086748	0	0	0	0	56.00
60.00	06000	LABORATORY	0.168759	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.423843	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.321497	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.163987	0	0	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.295873	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0.312352	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.195552	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.391448	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211708	0	0	703	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.260485	0	0	0	0	90.00
90.01	09001	IMED	0.000000	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.282106	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.570671	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	1.033767	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.160540	219	0	0	35	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.426743	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.469690		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		219	0	703	35	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		219	0	703	35	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Subprovider - IRF | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
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
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	PULMONARY	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	0		69.02
69.03	06903	SLEEP LAB	0	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	149		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	IMED	0	0		90.01
90.02	09002	ONCOLOGY	0	0		90.02
90.03	09003	OUTPATIENT CENTER	0	0		90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0		90.04
90.05	09005	DIABETES MGMT CLINIC	0	0		90.05
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	149		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	149		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/30/2021 2:40 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.263544	0	787,268	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.180996	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.644891	0	103,614	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087281	0	1,171,252	0	0	54.00
56.00	05600	RADIOISOTOPE	0.086748	0	90,466	0	0	56.00
60.00	06000	LABORATORY	0.168759	0	760,000	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.423843	0	10,333	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.321497	0	60,156	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.163987	0	282,530	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.295873	0	3,586	0	0	69.02
69.03	06903	SLEEP LAB	0.312352	0	5,490	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.195552	0	65,518	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.391448	0	35,210	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211708	0	2,111,350	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.260485	0	123,372	0	0	90.00
90.01	09001	IMED	0.000000	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.282106	0	285,501	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.570671	0	80,430	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	1.033767	0	2,476	0	0	90.05
91.00	09100	EMERGENCY	0.160540	0	1,469,495	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.426743	0	57,594	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.469690	0	261,929			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	7,767,570	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	7,767,570	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/30/2021 2:40 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	207,480	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	66,820	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	102,228	0	54.00
56.00	05600	RADIOISOTOPE	7,848	0	56.00
60.00	06000	LABORATORY	128,257	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,380	0	65.00
66.00	06600	PHYSICAL THERAPY	19,340	0	66.00
69.00	06900	ELECTROCARDIOLOGY	46,331	0	69.00
69.01	06901	PULMONARY	0	0	69.01
69.02	06902	CARDIOPULMONARY	1,061	0	69.02
69.03	06903	SLEEP LAB	1,715	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,812	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,783	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	446,990	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	32,137	0	90.00
90.01	09001	IMED	0	0	90.01
90.02	09002	ONCOLOGY	80,542	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	45,899	0	90.04
90.05	09005	DIABETES MGMT CLINIC	2,560	0	90.05
91.00	09100	EMERGENCY	235,913	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	24,578	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	123,025		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	1,603,699	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	1,603,699	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/30/2021 2:40 pm

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)	11,297	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,297	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)	8,651	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)	3,624	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)	10,459,469	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)	10,459,469	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)	10,459,469	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)	925.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,355,317	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)	3,355,317	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/30/2021 2:40 pm

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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,143,544	4,094	1,256.36	1,924	2,417,237	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)	9,463,779	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	15,236,333	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)	495,396	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	275,567	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	770,963	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	14,465,370	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)	2,646	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	925.86	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,449,826	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/30/2021 2:40 pm

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	921,563	10,459,469	0.088108	2,449,826	215,849	90.00
91.00	Nursing School cost	0	10,459,469	0.000000	2,449,826	0	91.00
92.00	Allied health cost	0	10,459,469	0.000000	2,449,826	0	92.00
93.00	All other Medical Education	0	10,459,469	0.000000	2,449,826	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 2:40 pm
	Title XVIII	Subprovider - IPF	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)	2,266	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,266	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,266	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)	884	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)	2,803,693	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)	2,803,693	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,803,693	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)	1,237.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,093,764	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,093,764	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Subprovider - IPF | 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	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)	161,905	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,255,669	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)	127,084	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	4,036	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	131,120	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,124,549	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1

Component CCN: 15-S115 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Subprovider - IPF | 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	325,765	2,803,693	0.116191	0	0	90.00
91.00	Nursing School cost	0	2,803,693	0.000000	0	0	91.00
92.00	Allied health cost	0	2,803,693	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,803,693	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 2:40 pm
	Title XVIII	Subprovider - IRF	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)	1,097	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,097	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,097	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)	517	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)	1,399,696	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)	1,399,696	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)	1,399,696	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)	1,275.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	659,656	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)	659,656	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Subprovider - IRF | 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	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)	249,420	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	909,076	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)	79,546	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	10,428	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	89,974	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	819,102	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Subprovider - IRF | 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	168,786	1,399,696	0.120588	0	0	90.00
91.00	Nursing School cost	0	1,399,696	0.000000	0	0	91.00
92.00	Allied health cost	0	1,399,696	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,399,696	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 2:40 pm
	Title XVIII	Skilled Nursing Facility	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)	4,334	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,334	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)	4,334	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)	3,459	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)	2,455,650	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)	2,455,650	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,455,650	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1

Component CCN: 15-5305 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Skilled Nursing Facility | 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						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,455,650	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	566.60	71.00
72.00	Program routine service cost (line 9 x line 71)	1,959,869	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,959,869	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,959,869	83.00
84.00	Program inpatient ancillary services (see instructions)	992,828	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,952,697	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 2:40 pm
	Title XVIII	Skilled Nursing Facility	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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,297	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,297	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)	8,651	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)	161	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)	1,378	15.00
16.00	Nursery days (title V or XIX only)	64	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)	10,459,469	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)	10,459,469	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)	10,459,469	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)	925.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	149,063	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)	149,063	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,125,670	1,378	816.89	64	52,281	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,143,544	4,094	1,256.36	84	105,534	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)	491,526	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	798,404	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)	2,646	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	925.86	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,449,826	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	921,563	10,459,469	0.088108	2,449,826	215,849	90.00
91.00	Nursing School cost	0	10,459,469	0.000000	2,449,826	0	91.00
92.00	Allied health cost	0	10,459,469	0.000000	2,449,826	0	92.00
93.00	All other Medical Education	0	10,459,469	0.000000	2,449,826	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 2:40 pm
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,266	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,266	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,266	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)	712	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)	1,378	15.00
16.00	Nursery days (title V or XIX only)	64	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)	2,803,693	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)	2,803,693	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,803,693	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)	1,237.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	880,950	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)	880,950	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	880,950	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XIX | Subprovider - IPF | 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	325,765	2,803,693	0.116191	0	0	90.00
91.00	Nursing School cost	0	2,803,693	0.000000	0	0	91.00
92.00	Allied health cost	0	2,803,693	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,803,693	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 2:40 pm
	Title XIX	Subprovider - IRF	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)	1,097	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,097	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,097	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)	0	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)	1,378	15.00
16.00	Nursery days (title V or XIX only)	64	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)	1,399,696	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)	1,399,696	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)	1,399,696	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)	1,275.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XIX | Subprovider - IRF | Cost

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115
Component CCN: 15-T115

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

Worksheet D-1
Date/Time Prepared:
11/30/2021 2:40 pm

Title XIX | Subprovider - IRF | 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	168,786	1,399,696	0.120588	0	0	90.00
91.00	Nursing School cost	0	1,399,696	0.000000	0	0	91.00
92.00	Allied health cost	0	1,399,696	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,399,696	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 2:40 pm
	Title XIX	Skilled Nursing Facility	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)	4,334	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,334	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)	4,334	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)	100	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)	1,378	15.00
16.00	Nursery days (title V or XIX only)	64	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)	2,455,650	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)	2,455,650	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,455,650	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1

Component CCN: 15-5305 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XIX | Skilled Nursing Facility | 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						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,455,650	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	566.60	71.00
72.00	Program routine service cost (line 9 x line 71)	56,660	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	56,660	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	197,957	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	45.68	76.00
77.00	Program capital-related costs (line 9 x line 76)	4,568	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	52,092	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	52,092	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	4,568	83.00
84.00	Program inpatient ancillary services (see instructions)	0	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	4,568	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Component CCN: 15-5305 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XIX | Skilled Nursing Facility | 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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 11/30/2021 2:40 pm

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		4,415,216		30.00
31.00	03100	INTENSIVE CARE UNIT		3,798,496		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.263544	4,495,668	1,184,806	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.180996	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.644891	242,908	156,649	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087281	5,628,186	491,234	54.00
56.00	05600	RADIOISOTOPE	0.086748	171,597	14,886	56.00
60.00	06000	LABORATORY	0.168759	4,486,762	757,181	60.00
65.00	06500	RESPIRATORY THERAPY	0.423843	659,666	279,595	65.00
66.00	06600	PHYSICAL THERAPY	0.321497	1,361,411	437,690	66.00
69.00	06900	ELECTROCARDIOLOGY	0.163987	6,103,254	1,000,854	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.295873	326	96	69.02
69.03	06903	SLEEP LAB	0.312352	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.195552	1,272,117	248,765	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.391448	3,694,845	1,446,340	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211708	12,036,406	2,548,203	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.260485	48,375	12,601	90.00
90.01	09001	IMED	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	0.282106	47,004	13,260	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.570671	3,134	1,788	90.04
90.05	09005	DIABETES MGMT CLINIC	1.033767	0	0	90.05
91.00	09100	EMERGENCY	0.160540	4,441,609	713,056	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.426743	367,376	156,775	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		45,060,644	9,463,779	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)		45,060,644		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Subprovider - IPF | 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				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF		1,323,100		40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.263544	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.180996	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.644891	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087281	116,604	10,177	54.00
56.00	05600	RADIOISOTOPE	0.086748	0	0	56.00
60.00	06000	LABORATORY	0.168759	245,860	41,491	60.00
65.00	06500	RESPIRATORY THERAPY	0.423843	468	198	65.00
66.00	06600	PHYSICAL THERAPY	0.321497	20,786	6,683	66.00
69.00	06900	ELECTROCARDIOLOGY	0.163987	25,089	4,114	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.295873	0	0	69.02
69.03	06903	SLEEP LAB	0.312352	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.195552	370	72	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.391448	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211708	294,922	62,437	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.260485	0	0	90.00
90.01	09001	IMED	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	0.282106	160	45	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.570671	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	1.033767	0	0	90.05
91.00	09100	EMERGENCY	0.160540	228,526	36,688	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.426743	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		932,785	161,905	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)		932,785		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Subprovider - IRF | 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				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF		645,216		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.263544	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.180996	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.644891	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087281	15,591	1,361	54.00
56.00	05600	RADIOISOTOPE	0.086748	0	0	56.00
60.00	06000	LABORATORY	0.168759	34,067	5,749	60.00
65.00	06500	RESPIRATORY THERAPY	0.423843	568	241	65.00
66.00	06600	PHYSICAL THERAPY	0.321497	666,545	214,292	66.00
69.00	06900	ELECTROCARDIOLOGY	0.163987	3,046	500	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.295873	0	0	69.02
69.03	06903	SLEEP LAB	0.312352	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.195552	1,369	268	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.391448	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211708	126,590	26,800	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.260485	0	0	90.00
90.01	09001	IMED	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	0.282106	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.570671	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	1.033767	0	0	90.05
91.00	09100	EMERGENCY	0.160540	1,300	209	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.426743	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		849,076	249,420	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)		849,076		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0115 | Component CCN: 15-5305 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Skilled Nursing Facility | 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				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.263544	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.180996	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.644891	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087281	35,155	3,068	54.00
56.00	05600	RADIOISOTOPE	0.086748	0	0	56.00
60.00	06000	LABORATORY	0.168759	420,316	70,932	60.00
65.00	06500	RESPIRATORY THERAPY	0.423843	4,494	1,905	65.00
66.00	06600	PHYSICAL THERAPY	0.321497	1,728,446	555,690	66.00
69.00	06900	ELECTROCARDIOLOGY	0.163987	42,909	7,037	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.295873	0	0	69.02
69.03	06903	SLEEP LAB	0.312352	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.195552	22,185	4,338	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.391448	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211708	1,652,552	349,858	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.260485	0	0	90.00
90.01	09001	IMED	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	0.282106	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.570671	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	1.033767	0	0	90.05
91.00	09100	EMERGENCY	0.160540	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.426743	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,906,057	992,828	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)		3,906,057		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		465,355		30.00
31.00	03100	INTENSIVE CARE UNIT		232,124		31.00
40.00	04000	SUBPROVIDER - IPF		200,678		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		111,450		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.263544	151,797	40,005	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.180996	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.644891	100,551	64,844	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087281	268,477	23,433	54.00
56.00	05600	RADIOISOTOPE	0.086748	11,048	958	56.00
60.00	06000	LABORATORY	0.168759	322,912	54,494	60.00
65.00	06500	RESPIRATORY THERAPY	0.423843	51,560	21,853	65.00
66.00	06600	PHYSICAL THERAPY	0.321497	51,673	16,613	66.00
69.00	06900	ELECTROCARDIOLOGY	0.163987	184,450	30,247	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.295873	0	0	69.02
69.03	06903	SLEEP LAB	0.312352	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.195552	26,437	5,170	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.391448	55,094	21,566	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211708	774,319	163,930	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.838310	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.019864	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.260485	1,196	312	90.00
90.01	09001	IMED	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	0.282106	6,664	1,880	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.570671	322	184	90.04
90.05	09005	DIABETES MGMT CLINIC	1.033767	0	0	90.05
91.00	09100	EMERGENCY	0.160540	282,572	45,364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.426743	1,578	673	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,290,650	491,526	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)		2,290,650		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF		200,950		40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.263544	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.180996	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.644891	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087281	0	0	54.00
56.00	05600	RADIOISOTOPE	0.086748	0	0	56.00
60.00	06000	LABORATORY	0.168759	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.423843	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.321497	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.163987	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.295873	0	0	69.02
69.03	06903	SLEEP LAB	0.312352	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.195552	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.391448	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211708	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.838310	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.019864	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.260485	0	0	90.00
90.01	09001	IMED	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	0.282106	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.570671	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	1.033767	0	0	90.05
91.00	09100	EMERGENCY	0.160540	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.426743	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/30/2021 2:40 pm
	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)	3,869,203	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	12,074,986	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)	14,805	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	14,299	2.04
3.00	Managed Care Simulated Payments	3,421,916	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	88.45	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	9.35	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	9.35	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.105709	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.105614	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.105614	21.00
22.00	IME payment adjustment (see instructions)	893,273	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	191,713	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)	893,273	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	191,713	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.33	30.00
31.00	Percentage of Medicaid patient days (see instructions)	17.64	31.00
32.00	Sum of lines 30 and 31	19.97	32.00
33.00	Allowable disproportionate share percentage (see instructions)	5.73	33.00
34.00	Disproportionate share adjustment (see instructions)	228,400	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/30/2021 2:40 pm
	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)	8,350,599,096	8,290,014,521	35.00
35.01	Factor 3 (see instructions)	0.000149452	0.000159904	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,248,010	1,325,606	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	313,707	991,480	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,305,187		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		40.00

		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	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 excluding MS-DRGs 652, 682, 683, 684 an 685. (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	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)	18,400,153		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)	18,591,866	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,296,968	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).	237,349	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	104,244	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)	20,230,427	59.00
60.00	Primary payer payments	9,420	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	20,221,007	61.00
62.00	Deductibles billed to program beneficiaries	2,021,324	62.00
63.00	Coinsurance billed to program beneficiaries	1,855	63.00
64.00	Allowable bad debts (see instructions)	40,710	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	26,462	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	23,751	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	18,224,290	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)	39,269	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/30/2021 2:40 pm
	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)	2020	44,080	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)	2021	180,126	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		154,058	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		18,333,707	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		16,933,946	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)		1,399,761	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		0	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: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/30/2021 2:40 pm

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	3,869,203	0	3,869,203		3,869,203	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	12,074,986	0		12,074,986	12,074,986	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	14,805	0	14,805		14,805	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	14,299	0		14,299	14,299	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	3,421,916	0	927,392	2,494,524	3,421,916	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.105614	0.105614	0.105614	0.105614		5.00
6.00	IME payment adjustment (see instructions)	22.00	893,273	0	216,772	676,501	893,273	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	191,713	0	51,957	139,756	191,713	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	893,273	0	216,772	676,501	893,273	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	191,713	0	51,957	139,756	191,713	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0573	0.0573	0.0573	0.0573		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	228,400	0	55,426	172,974	228,400	11.00
11.01	Uncompensated care payments	36.00	1,305,187	0	313,707	991,480	1,305,187	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	18,400,153	0	4,469,913	13,930,240	18,400,153	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	18,591,866	0	4,521,870	14,069,996	18,591,866	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,296,968	0	326,908	970,060	1,296,968	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/30/2021 2:40 pm

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	
17.00	Special add-on payments for new technologies	54.00	104,244	0	0	104,244	104,244	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	4,848,778	15,144,300	19,993,078	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	1,203,478	0	303,343	900,135	1,203,478	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	1,785	0	450	1,335	1,785	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	0.0762	0.0762	0.0762	0.0762		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	91,705	0	23,115	68,590	91,705	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	1,296,968	0	326,908	970,060	1,296,968	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				0.009091	0.011894		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			44,080		44,080	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				180,126	180,126	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: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/30/2021 2:40 pm

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	3,869,203	3,869,203		3,869,203	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	12,074,986		12,074,986	12,074,986	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	14,805	14,805		14,805	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	14,299		14,299	14,299	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	3,421,916	0	3,421,916	3,421,916	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.105614	0.105614	0.105614		5.00
6.00	IME payment adjustment (see instructions)	22.00	893,273	216,772	676,501	893,273	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	191,713	0	191,713	191,713	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	893,273	216,772	676,501	893,273	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	191,713	0	191,713	191,713	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0573	0.0573	0.0573		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	228,400	55,426	172,974	228,400	11.00
11.01	Uncompensated care payments	36.00	1,305,187	313,707	991,480	1,305,187	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	18,400,153	4,469,913	13,930,240	18,400,153	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	18,591,866	4,469,913	14,121,953	18,591,866	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,296,968	326,908	970,060	1,296,968	16.00
17.00	Special add-on payments for new technologies	54.00	104,244	0	104,244	104,244	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			4,796,821	15,196,257	19,993,078	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/30/2021 2:40 pm

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	1,203,478	303,343	900,135	1,203,478	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	1,785	450	1,335	1,785	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	0.0762	0.0762	0.0762		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	91,705	23,115	68,590	91,705	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	1,296,968	326,908	970,060	1,296,968	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	44,080	44,080		44,080	28.00
29.00	Low volume adjustment on or after October 1	70.97	180,126		180,126	180,126	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	39,269	9,898	29,371	39,269	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	0	0	0	0	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	154,058	154,058	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/30/2021 2:40 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	12,259	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	26,778,674	2.00
3.00	OPPS payments	28,836,877	3.00
4.00	Outlier payment (see instructions)	17,239	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)	12,259	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	57,932	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)	57,932	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)	57,932	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	45,673	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	12,259	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)	28,854,116	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)	5,028,308	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)	23,838,067	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	303,071	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)	24,141,138	30.00
31.00	Primary payer payments	16,665	31.00
32.00	Subtotal (line 30 minus line 31)	24,124,473	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)	368,088	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	239,257	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	332,788	36.00
37.00	Subtotal (see instructions)	24,363,730	37.00
38.00	MSP-LCC reconciliation amount from PS&R	3,131	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)	24,360,599	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	24,242,279	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)	118,320	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/30/2021 2:40 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	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)	0	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)	0	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)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	0	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	0	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	0	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)	0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/30/2021 2:40 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	149	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	35	2.00
3.00	OPPS payments	105	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	149	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	703	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)	703	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)	703	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	554	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)	149	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)	105	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)	0	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)	254	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)	254	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	254	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	254	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	254	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	253	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)	1	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: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-1 Part I | Date/Time Prepared: 11/30/2021 2:40 pm

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		16,853,446		24,211,979	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	02/17/2021	80,500	02/17/2021	30,300	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		80,500		30,300	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)		16,933,946		24,242,279	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		1,399,761		118,320	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		18,333,707		24,360,599	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-1 Part I | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Subprovider - IPF | 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		797,376		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		797,376		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		47,499		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		844,875		0	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-1 Part I | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Subprovider - IRF | 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		931,959		253	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		931,959		253	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1	6.01
6.02	SETTLEMENT TO PROGRAM		9,108		0	6.02
7.00	Total Medicare program liability (see instructions)		922,851		254	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0115 | Component CCN: 15-5305 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-1 Part I | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Skilled Nursing Facility | 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		1,635,559		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,635,559		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		2,452		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,638,011		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part II Date/Time Prepared: 11/30/2021 2:40 pm
	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 from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		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: 15-0115 Component CCN: 15-S115	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part II Date/Time Prepared: 11/30/2021 2:40 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	889,668	1.00
2.00	Net IPF PPS Outlier Payments	17,814	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.51	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.51	8.00
9.00	Average Daily Census (see instructions)	6.208219	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.041497	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	36,919	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	944,401	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	944,401	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	944,401	18.00
19.00	Deductibles	89,044	19.00
20.00	Subtotal (line 18 minus line 19)	855,357	20.00
21.00	Coinsurance	21,062	21.00
22.00	Subtotal (line 20 minus line 21)	834,295	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	16,277	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	10,580	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,088	25.00
26.00	Subtotal (sum of lines 22 and 24)	844,875	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE ADJUSTMENTS)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	844,875	31.00
31.01	Sequestration adjustment (see instructions)	0	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	797,376	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	47,499	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	17,814	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part III Date/Time Prepared: 11/30/2021 2:40 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	910,302	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	21,301	3.00
4.00	Outlier Payments	0	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	3.005479	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	931,603	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	931,603	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	931,603	19.00
20.00	Deductibles	8,752	20.00
21.00	Subtotal (line 19 minus line 20)	922,851	21.00
22.00	Coinsurance	0	22.00
23.00	Subtotal (line 21 minus line 22)	922,851	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	922,851	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	922,851	32.00
32.01	Sequestration adjustment (see instructions)	0	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	931,959	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-9,108	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VI Date/Time Prepared: 11/30/2021 2:40 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,807,884	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,807,884	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	169,614	7.00
8.00	Allowable bad debts (see instructions)	3,772	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	3,772	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	2,452	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,640,722	12.00
13.00	Inpatient primary payer payments	2,711	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	1,638,011	15.00
15.01	Sequestration adjustment (see instructions)	0	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	0	15.75
16.00	Interim payments	1,635,559	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	2,452	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/30/2021 2:40 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	798,404		1.00
2.00	Medical and other services		1,603,699	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	798,404	1,603,699	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)	798,404	1,603,699	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	2,290,650	7,767,570	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)	2,290,650	7,767,570	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)	2,290,650	7,767,570	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,492,246	6,163,871	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)	798,404	1,603,699	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)	798,404	1,603,699	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)	798,404	1,603,699	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	798,404	1,603,699	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS)	-798,404	-1,603,699	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/30/2021 2:40 pm
	Title XIX	Subprovider - IPF	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	880,950		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)	880,950	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)	880,950	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	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)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	880,950	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	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)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	880,950	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/30/2021 2:40 pm
	Title XIX	Subprovider - IRF	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	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	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)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	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)	0	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)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/30/2021 2:40 pm
	Title XIX	Skilled Nursing Facility	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	4,568		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)	4,568	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)	4,568	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	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)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	4,568	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	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)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	4,568	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-4 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Hospital | PPS

		1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT		
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.	0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)	0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA	0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)	0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)	0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)	0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts	0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)	0.00	6.00
7.00	Enter the lesser of line 5 or line 6	0.00	7.00

		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	9.23	0.63		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	9.23	0.63		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	9.23	0.63		17.00
18.00	Per resident amount	105,000.00	105,000.00		18.00
19.00	Approved amount for resident costs	969,150	66,150	1,035,300	19.00

		1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)	0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)	0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)	0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)	0.00	23.00
24.00	Multiply line 22 time line 23	0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)	1,035,300	25.00

		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total	
		1.00	2.00	2.01	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	6,949	1,722	0		26.00
27.00	Total Inpatient Days (see instructions)	16,477	16,477	16,477		27.00
28.00	Ratio of inpatient days to total inpatient days	0.421739	0.104509	0.000000		28.00
29.00	Program direct GME amount	436,626	108,198	0	544,824	29.00
29.01	Percent reduction for MA DGME		4.07	4.07		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		4,404	0	4,404	30.00
31.00	Net Program direct GME amount				540,420	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet E-4 Date/Time Prepared: 11/30/2021 2:40 pm
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	21,168,831	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	12,131	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	21,156,700	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	27,031,785	42.00
43.00	Primary payer payments (see instructions)	16,786	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	27,014,999	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	48,171,699	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.439194	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.560806	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	540,420	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	237,349	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	303,071	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G | Date/Time Prepared: 11/30/2021 2:40 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	108,748,382	0	0	0	1.00
2.00	Temporary investments	74,327,955	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	21,101,195	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	7,025,685	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)	211,203,217	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	11,154,563	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	121,605,691	0	0	0	15.00
16.00	Accumulated depreciation	-81,521,740	0	0	0	16.00
17.00	Leasehold improvements	30,809,760	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	114,778,710	0	0	0	19.00
20.00	Accumulated depreciation	-80,955,556	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	115,871,428	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	33,536,396	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	17,648,558	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	51,184,954	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	378,259,599	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	30,406,213	0	0	0	37.00
38.00	Salaries, wages, and fees payable	33,271,879	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,324,544	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	5,554,559				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,862,118	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	79,419,313	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	67,575,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	67,575,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	146,994,313	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	231,265,286				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)	231,265,286	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	378,259,599	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G-1 | Date/Time Prepared: 11/30/2021 2:40 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		206,545,303		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		92,341,143				2.00
3.00	Total (sum of line 1 and line 2)		298,886,446		0		3.00
4.00	IDENTIFIED ON TB - FOUNDATION	-743,830		0		0	4.00
5.00	FREESTANDING RHC DEPARTMENTS	-13,328		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)		-757,158		0		10.00
11.00	Subtotal (line 3 plus line 10)		298,129,288		0		11.00
12.00	HOME OFFICE DEPARTMENTS	66,864,002		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)		66,864,002		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		231,265,286		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	IDENTIFIED ON TB - FOUNDATION		0			4.00
5.00	FREESTANDING RHC DEPARTMENTS		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	HOME OFFICE DEPARTMENTS		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: 15-0115 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/30/2021 2:40 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	21,018,989		21,018,989	1.00
2.00	SUBPROVIDER - IPF	3,962,465		3,962,465	2.00
3.00	SUBPROVIDER - IRF	1,405,292		1,405,292	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	1,313,302		1,313,302	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)	27,700,048		27,700,048	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	9,347,442		9,347,442	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)	9,347,442		9,347,442	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	37,047,490		37,047,490	17.00
18.00	Ancillary services	102,512,252	440,485,232	542,997,484	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	901,163	901,163	20.00
20.01	RURAL HEALTH CLINIC II	0	944,524	944,524	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,841,026	2,841,026	22.00
23.00	AMBULANCE SERVICES	1,342,119	4,547,571	5,889,690	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	PHYSICIANS	0	57,289,691	57,289,691	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	140,901,861	507,009,207	647,911,068	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		172,373,939		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)		172,373,939		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet G-3 Date/Time Prepared: 11/30/2021 2:40 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	647,911,068	1.00
2.00	Less contractual allowances and discounts on patients' accounts	411,818,042	2.00
3.00	Net patient revenues (line 1 minus line 2)	236,093,026	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	172,373,939	4.00
5.00	Net income from service to patients (line 3 minus line 4)	63,719,087	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	18,136,519	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	569,834	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	303,188	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	MISCELLANEOUS	3,012,515	24.00
24.50	COVID-19 PHE Funding	6,600,000	24.50
25.00	Total other income (sum of lines 6-24)	28,622,056	25.00
26.00	Total (line 5 plus line 25)	92,341,143	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	92,341,143	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0115 HHA CCN: 15-7222 | Period: From 07/01/2020 To 06/30/2021 | Worksheet H | Date/Time Prepared: 11/30/2021 2:40 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	1,983,501	0	170,440	56,883	70,152	2,280,976	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	55,954	55,954	12.00
13.00	Drugs	0	0	0	0	1,293	1,293	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,983,501	0	170,440	56,883	127,399	2,338,223	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-1,808,658	472,318	0	472,318			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	933,554	933,554	0	933,554			6.00
7.00	Physical Therapy	457,869	457,869	0	457,869			7.00
8.00	Occupational Therapy	257,804	257,804	0	257,804			8.00
9.00	Speech Pathology	13,179	13,179	0	13,179			9.00
10.00	Medical Social Services	8,399	8,399	0	8,399			10.00
11.00	Home Health Aide	137,853	137,853	0	137,853			11.00
12.00	Supplies (see instructions)	0	55,954	-55,954	0			12.00
13.00	Drugs	0	1,293	-1,293	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	2,338,223	-57,247	2,280,976			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 15-0115 HHA CCN: 15-7222

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

Worksheet H-1 Part I Date/Time Prepared: 11/30/2021 2:40 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	472,318	0	0	0	0	472,318	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	933,554	0	0	0	0	933,554	6.00
7.00	Physical Therapy	457,869	0	0	0	0	457,869	7.00
8.00	Occupational Therapy	257,804	0	0	0	0	257,804	8.00
9.00	Speech Pathology	13,179	0	0	0	0	13,179	9.00
10.00	Medical Social Services	8,399	0	0	0	0	8,399	10.00
11.00	Home Health Aide	137,853	0	0	0	0	137,853	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,280,976	0	0	0	0	2,280,976	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	472,318			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	243,791	1,177,345		6.00
7.00	Physical Therapy	119,569	577,438		7.00
8.00	Occupational Therapy	67,324	325,128		8.00
9.00	Speech Pathology	3,442	16,621		9.00
10.00	Medical Social Services	2,193	10,592		10.00
11.00	Home Health Aide	35,999	173,852		11.00
12.00	Supplies (see instructions)	0	0		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		2,280,976		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2020 To 06/30/2021 | Worksheet H-1 Part II Date/Time Prepared: 11/30/2021 2:40 pm

Home Health Agency I | PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-472,318	1,808,658	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	933,554	6.00
7.00	Physical Therapy	0	0	0	0	0	457,869	7.00
8.00	Occupational Therapy	0	0	0	0	0	257,804	8.00
9.00	Speech Pathology	0	0	0	0	0	13,179	9.00
10.00	Medical Social Services	0	0	0	0	0	8,399	10.00
11.00	Home Health Aide	0	0	0	0	0	137,853	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-472,318	1,808,658	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		472,318	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.261143	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0115 HHA CCN: 15-7222

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

Worksheet H-2 Part I Date/Time Prepared: 11/30/2021 2:40 pm

Home Health Agency I

PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	47,100	22,728	82,055	151,883	20,803	1.00
2.00	Skilled Nursing Care	1,177,345	0	0	203,917	1,381,262	189,184	2.00
3.00	Physical Therapy	577,438	0	0	98,475	675,913	92,576	3.00
4.00	Occupational Therapy	325,128	0	0	55,790	380,918	52,172	4.00
5.00	Speech Pathology	16,621	0	0	2,906	19,527	2,674	5.00
6.00	Medical Social Services	10,592	0	0	1,888	12,480	1,709	6.00
7.00	Home Health Aide	173,852	0	0	26,335	200,187	27,418	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	2,280,976	47,100	22,728	471,366	2,822,170	386,536	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		6.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	42,004	0	8,190	0	7,894	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	18,354	0	2.00
3.00	Physical Therapy	0	0	0	0	7,964	0	3.00
4.00	Occupational Therapy	0	0	0	0	4,153	0	4.00
5.00	Speech Pathology	0	0	0	0	216	0	5.00
6.00	Medical Social Services	0	0	0	0	229	0	6.00
7.00	Home Health Aide	0	0	0	0	4,485	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	42,004	0	8,190	0	43,295	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0115 HHA CCN: 15-7222 | Period: From 07/01/2020 To 06/30/2021 | Worksheet H-2 Part I Date/Time Prepared: 11/30/2021 2:40 pm

Home Health Agency I | PPS

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	Subtotal	
		14.00	15.00	16.00	21.00	22.00	24.00	
1.00	Administrative and General	1,480	0	0	0	0	232,254	1.00
2.00	Skilled Nursing Care	0	0	4,157	0	0	1,592,957	2.00
3.00	Physical Therapy	0	0	2,395	0	0	778,848	3.00
4.00	Occupational Therapy	0	0	1,269	0	0	438,512	4.00
5.00	Speech Pathology	0	0	52	0	0	22,469	5.00
6.00	Medical Social Services	0	0	25	0	0	14,443	6.00
7.00	Home Health Aide	0	0	1,489	0	0	233,579	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,480	0	9,387	0	0	3,313,062	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	232,254					1.00
2.00	Skilled Nursing Care	0	1,592,957	120,089	1,713,046			2.00
3.00	Physical Therapy	0	778,848	58,715	837,563			3.00
4.00	Occupational Therapy	0	438,512	33,058	471,570			4.00
5.00	Speech Pathology	0	22,469	1,694	24,163			5.00
6.00	Medical Social Services	0	14,443	1,089	15,532			6.00
7.00	Home Health Aide	0	233,579	17,609	251,188			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	0	3,313,062	232,254	3,313,062			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.075387				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0115 HHA CCN: 15-7222

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

Worksheet H-2 Part II Date/Time Prepared: 11/30/2021 2:40 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	3,758	3,758	339,119	0	151,883	3,758	1.00
2.00	Skilled Nursing Care	0	0	842,760	0	1,381,262	0	2.00
3.00	Physical Therapy	0	0	406,982	0	675,913	0	3.00
4.00	Occupational Therapy	0	0	230,572	0	380,918	0	4.00
5.00	Speech Pathology	0	0	12,009	0	19,527	0	5.00
6.00	Medical Social Services	0	0	7,804	0	12,480	0	6.00
7.00	Home Health Aide	0	0	108,837	0	200,187	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3,758	3,758	1,948,083		2,822,170	3,758	20.00
21.00	Total cost to be allocated	47,100	22,728	471,366		386,536	42,004	21.00
22.00	Unit cost multiplier	12.533262	6.047898	0.241964		0.136964	11.177222	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	3,758	0	12,156	0	29,872	1.00
2.00	Skilled Nursing Care	0	0	0	28,265	0	0	2.00
3.00	Physical Therapy	0	0	0	12,264	0	0	3.00
4.00	Occupational Therapy	0	0	0	6,395	0	0	4.00
5.00	Speech Pathology	0	0	0	332	0	0	5.00
6.00	Medical Social Services	0	0	0	353	0	0	6.00
7.00	Home Health Aide	0	0	0	6,906	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	3,758	0	66,671	0	29,872	20.00
21.00	Total cost to be allocated	0	8,190	0	43,295	0	1,480	21.00
22.00	Unit cost multiplier	0.000000	2.179351	0.000000	0.649383	0.000000	0.049545	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0115 HHA CCN: 15-7222

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

Worksheet H-2 Part II Date/Time Prepared: 11/30/2021 2:40 pm

Home Health Agency I

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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)			
		15.00	16.00	21.00	22.00			
1.00	Administrative and General	0	0	0	0			1.00
2.00	Skilled Nursing Care	0	1,258,028	0	0			2.00
3.00	Physical Therapy	0	724,873	0	0			3.00
4.00	Occupational Therapy	0	384,041	0	0			4.00
5.00	Speech Pathology	0	15,863	0	0			5.00
6.00	Medical Social Services	0	7,554	0	0			6.00
7.00	Home Health Aide	0	450,667	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19)	0	2,841,026	0	0			20.00
21.00	Total cost to be allocated	0	9,387	0	0			21.00
22.00	Unit cost multiplier	0.000000	0.003304	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2020 To 06/30/2021 | Worksheet H-3 Part I | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,713,046		1,713,046	8,327	205.72	1.00
2.00	Physical Therapy	3.00	837,563	0	837,563	4,798	174.57	2.00
3.00	Occupational Therapy	4.00	471,570	0	471,570	2,542	185.51	3.00
4.00	Speech Pathology	5.00	24,163	0	24,163	105	230.12	4.00
5.00	Medical Social Services	6.00	15,532		15,532	50	310.64	5.00
6.00	Home Health Aide	7.00	251,188		251,188	2,983	84.21	6.00
7.00	Total (sum of lines 1-6)		3,313,062	0	3,313,062	18,805		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	5,322			8.00
9.00	Physical Therapy		99915	0	3,325			9.00
10.00	Occupational Therapy		99915	0	1,738			10.00
11.00	Speech Pathology		99915	0	74			11.00
12.00	Medical Social Services		99915	0	27			12.00
13.00	Home Health Aide		99915	0	1,953			13.00
14.00	Total (sum of lines 8-13)			0	12,439			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	114,827	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	5,322		0	1,094,842		1.00
2.00	Physical Therapy	0	3,325		0	580,445		2.00
3.00	Occupational Therapy	0	1,738		0	322,416		3.00
4.00	Speech Pathology	0	74		0	17,029		4.00
5.00	Medical Social Services	0	27		0	8,387		5.00
6.00	Home Health Aide	0	1,953		0	164,462		6.00
7.00	Total (sum of lines 1-6)	0	12,439		0	2,187,581		7.00

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-0115 HHA CCN: 15-7222 | Period: From 07/01/2020 To 06/30/2021 | Worksheet H-3 Part I Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	1,094,842	1.00
2.00	Physical Therapy	580,445	2.00
3.00	Occupational Therapy	322,416	3.00
4.00	Speech Pathology	17,029	4.00
5.00	Medical Social Services	8,387	5.00
6.00	Home Health Aide	164,462	6.00
7.00	Total (sum of lines 1-6)	2,187,581	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
9.00	Physical Therapy		9.00
10.00	Occupational Therapy		10.00
11.00	Speech Pathology		11.00
12.00	Medical Social Services		12.00
13.00	Home Health Aide		13.00
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0115 HHA CCN: 15-7222 | Period: From 07/01/2020 To 06/30/2021 | Worksheet H-3 Part II Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.321497	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.195552	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.211708	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2020 To 06/30/2021 | Worksheet H-4 Part I-II | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	1,541,577	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	332,758	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	27,273	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	2,891	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	80,957	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	1,985,456	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	1,985,456	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	1,985,456	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	1,985,456	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	1,985,456	31.00
31.01	Sequestration adjustment (see instructions)	0	0	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	1,985,457	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	-1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0115 HHA CCN: 15-7222 | Period: From 07/01/2020 To 06/30/2021 | Worksheet H-5 Date/Time Prepared: 11/30/2021 2:40 pm

Home Health Agency I | 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		0		1,985,457	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		1,985,457	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1	6.02
7.00	Total Medicare program liability (see instructions)		0		1,985,456	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Prepared: 11/30/2021 2:40 pm
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier		1,203,478	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		1,785	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)		35.93	3.00
4.00	Number of interns & residents (see instructions)		9.35	4.00
5.00	Indirect medical education percentage (see instructions)		7.62	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)		91,705	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)		1,296,968	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: 15-0115 | Component CCN: 15-8507 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-1 | Date/Time Prepared: 11/30/2021 2:40 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	380,806	0	380,806	-316,833	63,973	1.00
2.00	Physician Assistant	0	0	0	1,575	1,575	2.00
3.00	Nurse Practitioner	0	0	0	192,654	192,654	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	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	82,447	82,447	9.00
10.00	Subtotal (sum of lines 1 through 9)	380,806	0	380,806	-40,157	340,649	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	340	340	0	340	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	340	340	0	340	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	380,806	340	381,146	-40,157	340,989	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	8,421	8,421	0	8,421	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	3,370	3,370	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	8,421	8,421	3,370	11,791	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	54,049	54,049	-416	53,633	29.00
30.00	Administrative Costs	0	36,195	36,195	37,203	73,398	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	90,244	90,244	36,787	127,031	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	380,806	99,005	479,811	0	479,811	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0115 | Component CCN: 15-8507 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-1 | Date/Time Prepared: 11/30/2021 2:40 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	63,973		1.00
2.00	Physician Assistant	0	1,575		2.00
3.00	Nurse Practitioner	0	192,654		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	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	82,447		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	340,649		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	340		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	340		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	340,989		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	8,421		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	3,370		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	11,791		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	53,633		29.00
30.00	Administrative Costs	-666	72,732		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-666	126,365		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-666	479,145		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0115 | Component CCN: 15-8508 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-1 | Date/Time Prepared: 11/30/2021 2:40 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	472,041	0	472,041	-347,914	124,127	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	165,929	165,929	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	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	114,402	114,402	9.00
10.00	Subtotal (sum of lines 1 through 9)	472,041	0	472,041	-67,583	404,458	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	782	782	0	782	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	782	782	0	782	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	472,041	782	472,823	-67,583	405,240	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	11,322	11,322	0	11,322	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	2,551	2,551	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	11,322	11,322	2,551	13,873	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	2,332	2,332	-5	2,327	29.00
30.00	Administrative Costs	0	41,510	41,510	65,037	106,547	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	43,842	43,842	65,032	108,874	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	472,041	55,946	527,987	0	527,987	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0115 | Component CCN: 15-8508 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-1 | Date/Time Prepared: 11/30/2021 2:40 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	124,127		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	165,929		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	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	114,402		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	404,458		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	782		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	782		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	405,240		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	11,322		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	2,551		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	13,873		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	2,327		29.00
30.00	Administrative Costs	-838	105,709		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-838	108,036		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-838	527,149		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0115 | Component CCN: 15-8507 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-2 | Date/Time Prepared: 11/30/2021 2:40 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	RHC I Cost: Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.08	724	4,200	336		1.00
2.00	Physician Assistant	0.02	48	2,100	42		2.00
3.00	Nurse Practitioner	1.18	3,271	2,100	2,478		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.28	4,043		2,856	4,043	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.28	4,043			4,043	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)					340,989	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					11,791	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					352,780	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.966577	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					126,365	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					276,309	15.00
16.00	Total overhead (sum of lines 14 and 15)					402,674	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					402,674	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					389,215	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					730,204	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0115 | Component CCN: 15-8508 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-2 | Date/Time Prepared: 11/30/2021 2:40 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC II Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.80	1,651	4,200	3,360		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.40	2,792	2,100	2,940		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.20	4,443		6,300	6,300	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.20	4,443			6,300	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)					405,240	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					13,873	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					419,113	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.966899	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					108,036	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					436,137	15.00
16.00	Total overhead (sum of lines 14 and 15)					544,173	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					544,173	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					526,160	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					931,400	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0115 Component CCN: 15-8507	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/30/2021 2:40 pm
	Title XVIII	RHC I	Cost

					1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)				730,204	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)				20,859	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)				709,345	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)				4,043	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)				0	5.00
6.00	Total adjusted visits (line 4 plus line 5)				4,043	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)				175.45	7.00
		Calculation of Limit (1)				
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)		
		1.00	2.00	3.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	0.00		8.00
9.00	Rate for Program covered visits (see instructions)	86.31	87.52	0.00		9.00
	CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	661	662	0		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	57,051	57,938	0		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	114,989			16.00
16.01	Total program charges (see instructions)(from contractor's records)		295,793			16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,266			16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,270			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.)		66,262			16.04
16.05	Total program cost (see instructions)	0	67,532			16.05
17.00	Primary payer amounts		54			17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		30,891			18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		52,327			19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		67,478			20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		14,066			21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		81,544			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)		81,544			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		68,211			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)		13,333			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: 15-0115 Component CCN: 15-8508	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/30/2021 2:40 pm
	Title XVIII	RHC II	Cost

					1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)				931,400	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)				35,255	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)				896,145	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)				6,300	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)				6,300	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)				142.25	7.00
		Calculation of Limit (1)				
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)		
		1.00	2.00	3.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	0.00		8.00
9.00	Rate for Program covered visits (see instructions)	86.31	87.52	0.00		9.00
	CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	723	723	0		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	62,402	63,277	0		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	125,679			16.00
16.01	Total program charges (see instructions)(from contractor's records)		272,299			16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		432			16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		199			16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		67,291			16.04
16.05	Total program cost (see instructions)	0	67,490			16.05
17.00	Primary payer amounts		67			17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		41,366			18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		46,100			19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		67,423			20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		19,099			21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		86,522			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)		86,522			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		67,627			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)		18,895			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: 15-0115 | Component CCN: 15-8507 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-4 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	340,649	340,649	340,649	340,649	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000390	0.005137	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	133	1,750	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2,916	4,942	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	3,049	6,692	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	340,989	340,989	340,989	340,989	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	389,215	389,215	389,215	389,215	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.008942	0.019625	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,480	7,638	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6,529	14,330	0	0	10.00
11.00	Total number of injections/infusions (from your records)	16	211	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	408.06	67.91	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	14	123	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)	5,713	8,353	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)		20,859			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)		14,066			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0115 | Component CCN: 15-8508 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-4 | Date/Time Prepared: 11/30/2021 2:40 pm

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	404,458	404,458	404,458	404,458	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000799	0.004696	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	323	1,899	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	7,473	5,644	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	7,796	7,543	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	405,240	405,240	405,240	405,240	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	526,160	526,160	526,160	526,160	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.019238	0.018614	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	10,122	9,794	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	17,918	17,337	0	0	10.00
11.00	Total number of injections/infusions (from your records)	41	241	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	437.02	71.94	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	20	144	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)	8,740	10,359	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)		35,255			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)		19,099			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0115 Component CCN: 15-8507	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/30/2021 2:40 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		68,211	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)		68,211	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		13,333	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		81,544	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: 15-0115 Component CCN: 15-8508	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/30/2021 2:40 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		67,627	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)		67,627	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		18,895	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		86,522	7.00

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