HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0102 Peri od. From 01/01/2020 AND SETTLEMENT SUMMARY 12/31/2020

		7/29/2021 3: 27 pm
PART I - COST	REPORT STATUS	
Provi der	 [X] Electronically prepared cost report 	Date: 7/29/2021 Time: 3:27 pm
use only	2. []Manually prepared cost report	
	3. [0]If this is an amended report enter the number of the 4. [F]Medicare Utilization. Enter "F" for full or "L" for	
Contractor use only	 5. [1] Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for thi (3) Settled with Audit (4) Reopened (5) Amended 	10. NPR Date: 11. Contractor's Vendor Code: 4 s Provider CCN 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 OF 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 STARKE MEMORIAL HOSPITAL (15-0102) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 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.

(Si aned)

Officer or Administrator of Provider(s)

In Lieu of Form CMS-2552-10

Worksheet S Parts I-III

OMB NO. 0938-0050 EXPIRES 03-31-2022

Date/Time Prenared

Title

Date

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	102, 458	41, 951	0	-5, 571	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	102, 458	41, 951	0	-5, 571	200.00

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

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX I		MEMORIAL H		CN: 15-0102	Peri od:		u of Form CMS- Worksheet S-2	
						From 01/0	1/2020 1/2020	Part I	
	1.00	2	00	3.0			4.00	7/29/2021 3:2	
	Hospital and Hospital Health Care Co		00	3.0	5		4.00		
00	Street: 102 EAST CULVER RD	P0 Box:							1. (
00	City: KNOX	State: I		ip Code: 46 CCN C	534 Cou 3SA Provid	inty: STARKE er Date	Baymo	ent System (P,	2.0
		Component Na			nber Type			, 0, or N)	
							V	XVIII XIX	1
	Uponital and Uponital Decod Company	1.00		2.00 3	00 4.00	5.00	6.00	0 7.00 8.00	
00	<u>Hospital and Hospital-Based Componen</u> Hospital	STARKE MEMORIAL		50102 99	915 1	07/11/19	66 N	P P	3. (
		HOSPI TAL							
00 00	Subprovider - IPF Subprovider - IRF								4.
00	Subprovider - (Other)								6.
00	Swing Beds - SNF								7.
00	Swing Beds - NF								8.
00 . 00	Hospital-Based SNF Hospital-Based NF								9.
. 00	Hospi tal -Based OLTC								11.
. 00	Hospital-Based HHA								12.
. 00	Separately Certified ASC Hospital-Based Hospice								13.
00	Hospital-Based Health Clinic - RHC								14.
00	Hospital-Based Health Clinic - FQHC								16.
00	Hospital-Based (CMHC)								17.
10 00	Hospital-Based (CORF) I Renal Dialysis								17.
	Other								19.
						Fro		To:	-
00	Cost Reporting Period (mm/dd/yyyy)					1.		2.00	20.
	Type of Control (see instructions)								21.
					1.00	2.	00	3.00	-
	Inpatient PPS Information				1.00	۷.	00	3.00	
00	Does this facility qualify and is it	2	0.5		Y	1	1		22.
	disproportionate share hospital adju: §412.106? In column 1, enter "Y" fo								
	facility subject to 42 CFR Section §								
	hospital?) In column 2, enter "Y" fo								
01	Did this hospital receive interim un cost reporting period? Enter in colu				Y)	,		22.
	the portion of the cost reporting pe								
	Enter in column 2, "Y" for yes or "N								
02	reporting period occurring on or aft Is this a newly merged hospital that				N	N			22.
02	payments to be determined at cost re						·		22.
	Enter in column 1, "Y" for yes or "N	" for no, for the	portion c	of the					
	cost reporting period prior to Octob or "N" for no, for the portion of th								
	October 1.	cost reporting	periou oli	or arter					
03	Did this hospital receive a geograph				N	М	1	Ν	22.
	rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c								
	for the portion of the cost reporting								
	in column 2, "Y" for yes or "N" for	no for the portio	on of the c	cost					
	reporting period occurring on or aft Does this hospital contain at least								
	counted in accordance with 42 CFR 41.								
	ves or "N" for no.	,							
						3 1	1		23.
00	Which method is used to determine Me	of odmicolon 11							
00	Which method is used to determine Me below? In column 1, enter 1 if date		ie davs in						
00	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the	of identifying th method used in th	e prior co						1
00	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method	of identifying th method used in th	e prior co "N" for no)	0.1+		Madia	id Other	
00	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the	of identifying th method used in th	e prior co			Out-of State	Medica HMO da		
00	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the	of identifying th method used in th	ne prior co <u>"N" for no</u> In-State). In-State Medicaid eligible	State Medi cai d	State Medi cai d			
00	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the	of identifying th method used in th	ne prior co "N" for no In-State Medicaid). In-State Medicaid eligible unpaid	State	State Medi cai d el i gi bl e		ys Medicaid	
00	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the	of identifying th method used in th	ne prior co "N" for no In-State Medicaid paid days). In-State Medicaid eligible unpaid days	State Medicaid paid days	State Medi cai d el i gi bl e unpai d	HMO da	ys Medi cai d days	
	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the	of identifying th method used in th r "Y" for yes or	ne prior co "N" for no In-State Medicaid). In-State Medicaid eligible unpaid days 2.00	State Medi cai d	State Medi cai d el i gi bl e unpai d 4.00	HMO da	Medi cai d days 6 6.00) 24.
	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, ente If this provider is an IPPS hospital in-state Medicaid paid days in colum	of identifying th method used in th r "Y" for yes or , enter the n 1, in-state	ne prior cc "N" for nc In-State Medicaid paid days 1.00). In-State Medicaid eligible unpaid days 2.00	State Medicaid paid days 3.00	State Medi cai d el i gi bl e unpai d 4.00	HMO da	Medi cai d days 6 6.00) 24.
. 00	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, ente If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	of identifying th method used in th r "Y" for yes or , enter the n 1, in-state umn 2,	ne prior cc "N" for nc In-State Medicaid paid days 1.00). In-State Medicaid eligible unpaid days 2.00	State Medicaid paid days 3.00	State Medi cai d el i gi bl e unpai d 4.00	HMO da	Medi cai d days 6 6.00) 24.
	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, ente If this provider is an IPPS hospital in-state Medicaid paid days in colum	of identifying th method used in th r "Y" for yes or , enter the n 1, in-state umn 2, olumn 3, d days in column	ne prior cc "N" for nc In-State Medicaid paid days 1.00). In-State Medicaid eligible unpaid days 2.00	State Medicaid paid days 3.00	State Medi cai d el i gi bl e unpai d 4.00	HMO da	Medi cai d days 6 6.00) 24.

SPI T	Financial Systems STARKE AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	MEMORIAL H	Provider CC	CN: 15-0102	Period: From 01/0	In Lieu		eet S-2	
						1/2020	Date/Ti	ime Pre	epare
		In-State Medicaid paid days	In-State Medicaid eligible unpaid	Out-of State Medicaid paid days	Out-of State Medicaid eligible	Medi ca HMO dag	ys Med	di cai d days	<u>27 pm</u>
		1.00	days	0.00	unpai d				_
5.00	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	2.00 0	3.00	4.00	5.00	0	6.00	25.
					Urban/R 1. (- Geogr 00	
. 00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for		at the beg	jinning of t	he	2			26.
. 00	Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status ~ "2" for r	ural. If ap		t	2			27.
. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods SC	CH status in		0			35.
					Begi nr		Endi		-
. 00	Enter applicable beginning and ending dates of SCH st	tatus. Subs	cript line	36 for numb	1.(er		2.	00	36
00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		r of perioc	ls MDH statu	s	1			37
01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)								37
100 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 01/01/2020 12/31/2020 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38	
					Y/		Y/	′N 00	-
. 00 . 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October 1), (ii), or the mileage i)? Enter n adjustmen per 1. Ente	(iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y	er in colum nts in ? "Y" for ye (" for yes o	n s r Y		Ŷ		39 40
	no in column 2, for discharges on or after October 1.	(see mst	ructrons)			V	XVIII	XI X	
	Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
00	Does this facility qualify and receive Capital paymer	nt for disp	roporti onat	e share in	accordance	N	N	N	45
00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N	N	N	46
	Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47 48
00	Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you i GME payment reduction? Enter "Y" for yes or "N" for	mpacted by	CR 11642 (- N			56
	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	period duri yes or "N th of this (", complet , if appli	ng which re "for noir cost report e Worksheet cable.	n column 1. ing period? E-4. lf co	If column 1 Enter "Y" lumn 2 is				57
00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			ans' servi ce	s as				58
00	Are costs claimed on line 100 of Worksheet A? If yes				We selve h	N		 	59
				NAHE 413.8 Y/N	35 Worksh Line	e #	Pass-T Qualifi Criteri	cation	
				1.00	2.0	00	3.	00	
. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C	85? (see umn 1. If	column 1	N					60

IOSPI TAL	L AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC		eriod: rom 01/01/2020 p 12/31/2020	Worksheet S-2 Part I Date/Time Pre 7/29/2021 3:2	pared:
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
50 1.01 Er F	id your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in solumn 1. (see instructions) inter the average number of unweighted primary care TEs from the hospital's 3 most recent cost reports anding and submitted before March 23, 2010. (see	N			0.00) O. OC	61.0
1.02 Er F ar	nstructions) inter the current year total unweighted primary care TE count (excluding OB/GYN, general surgery FTEs, nd primary care FTEs added under section 5503 of						61.0
1.03 Er ar de	CA). (see instructions) nter the base line FTE count for primary care nd/or general surgery residents, which is used for letermining compliance with the 75% test. (see nstructions)						61.0
1.04 Er	inter the number of unweighted primary care/or urgery allopathic and/or osteopathic FTEs in the urrent cost reporting period. (see instructions).						61.0
1.05 Er ar pr 6	nter the difference between the baseline primary nd/or general surgery FTEs and the current year's rimary care and/or general surgery FTE counts (line 1.04 minus line 61.03). (see instructions)						61.0
us	nter the amount of ACA §5503 award that is being sed for cap relief and/or FTEs that are nonprimary are or general surgery. (see instructions)						61.0
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
5 fc cc pr ur F 1. 20 0 f r f i r f 3,	If the FTEs in line 61.05, specify each new program pecialty, 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 nweighted count. Enter in column 4, the direct GME TE unweighted count. If the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE esidents for each expanded program. (see nstructions) Enter in column 1, the program name. Inter in column 2, the program code. Enter in column 4, he lime FTE unweighted count.				0.00		61. 1
						1.00	1
	CA Provisions Affecting the Health Resources and Ser						
2. 01 Er di	nter the number of FTE residents that your hospital our hospital received HRSA PCRE funding (see instruc- inter the number of FTE residents that rotated from a luring in this cost reporting period of HRSA THC prog eaching Hospitals that Claim Residents in Nonprovide	tions) Teachi ram. (s	ng Health Cent see instruction	ter (THC) into			62.0 62.0
3.00 Ha	las your facility trained residents in nonprovider se Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this co	67. (see instru	ictions)	N	63. 0
				Unweighted FTEs Nonprovider Site	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	-
C.	ection 5504 of the ACA Base Year FTE Residents in No	nnrovi	dar Sattings	1.00	2.00	3.00	
4.00 Er ir re se	ection 5504 of the ACA base year fit kesidents in we eriod that begins on or after July 1, 2009 and befor inter in column 1, if line 63 is yes, or your facilit n the base year period, the number of unweighted non esident FTEs attributable to rotations occurring in ettings. Enter in column 2 the number of unweighted esident FTEs that trained in your hospital. Enter in f (column 1 divided by (column 1 + column 2)). (see	<u>e June</u> y trair -primar all nor non-pr columr	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0.00			64.0

IOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DA	TA Provider (eriod: rom 01/01/2020		
			T	o 12/31/2020	Date/Time Pre 7/29/2021 3:2	pared:
	Program Name	Program Code	Unwei ghted	Unweighted	Ratio (col. 3/	
			FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
_	1 00	2.00	Si te	4.00	F 00	-
5.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	65.0
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)						
			Unweighted	Unweighted	Ratio (col. 1/	
			FTEs Nonprovider	FTEs in Hospital	(col. 1 + col. 2))	
			Si te			-
Section 5504 of the ACA Current Y	aar FTF Pasidants in	Nonnrovider Settin	1.00	2.00	3.00	
beginning on or after July 1, 201		i Nonprovider Setting	gsLitective it		ng perious	
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	I. Enter in column 3	s the ratio of	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	-
 7.00 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 3 divided by (column 3 + column 4)). (see instructions) 			0. 00) O. OC	0. 000000	67.00
				1.0	0 2.00 3.00	-
Inpatient Psychiatric Facility PP					2.00 3.00	70.5
0.00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no.	chiatric Facility (I	PF), or does it cont	tain an IPF subp	provider? N		70.0
1.00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic (see instructions) Inpatient Rehabilitation Facility	fore November 15, 20 umn 2: Did this faci 412.424 (d)(1)(iii) ate which program ye	004? Enter "Y" for y lity train residents (D)? Enter "Y" for y	/es or "N" for r s in a new teach /es or "N" for r	no. (see ni ng no.	0	71.0
5.00 Is this facility an Inpatient Reh	abilitation Facility	(IRF), or does it o	contain an IRF	N		75.0
Subprovider? Enter "Y" for yes a If line 75 is yes: Column 1: Did recent cost reporting period endi no. Column 2: Did this facility t	the facility have ar ng on or before Nove	ember 15, 2004? Enter	"Y" for yes or	"N" for	0	76.00

Health Financial Systems STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der		Period: From 01/01/2020	Worksheet S- Part I	
			To 12/31/2020	Date/Time Pr 7/29/2021 3:	
				1/24/2021 3.	
Long Term Care Hospital PPS				1.00	_
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for ye 81.00 Is this a LTCH co-located within another hospital for part "Y" for yes and "N" for no.			period? Enter	N N	80. 00 81. 00
TEFRA Providers				N	05.00
 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i 86.00 Did this facility establish a new Other subprovider (exclud §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 				N	85.00 86.00
87.00 Is this hospital an extended neoplastic disease care hospit 1886(d) (1) (B) (vi)? Enter "Y" for yes or "N" for no.	al classified	under section		Ν	87.00
			V	XI X	
Title V and XIX Services			1.00	2.00	
90.00 Does this facility have title V and/or XIX inpatient hospit	al services?	Enter "Y" for	N	Y	90.00
yes or "N" for no in the applicable column.	the east rang	nt sither in	N	V	01 00
91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the app			N	Y	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (instructions) Enter "Y" for yes or "N" for no in the applic	lual certifica			Ν	92.00
93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.	of title V a	nd XIX? Enter	N	Ν	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for	no in the	N	Ν	94.00
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the ap	plicable colu	mn.	0.00	0.00	95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column.			N	Ν	96.00
97.00 If line 96 is "Y", enter the reduction percentage in the ap			0.00	0.00 Y	97.00 98.00
98.00 Does title V or XIX follow Medicare (title XVIII) for the i stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y"			N	T	98.00
 column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t 			Ν	Υ	98. 01
 title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the obed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes 			N	Y	98. 02
 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y 			N	Ν	98. 03
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAP outpatient services cost? Enter "Y" for yes or "N" for no i	l reimbursed 1	01% of	Ν	Ν	98.04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add b			N	Y	98. 05
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.				·	70.00
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum			Ν	Y	98.06
column 2 for title XIX. 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 for outpatient services? (see instructions)	-inclusive me	thod of payment	-		106.00
107.00 Column 1: If line 105 is Y, is this facility eligible for c training programs? Enter "Y" for yes or "N" for no in colum	ost reimburse	ment for I&R			107.00
Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded I	you train I&	Rs in an			
Enter "Y" for yes or "N" for no in column 2. (see instruct		un t(3):			
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	e CRNA fee sch	edul e? See 42	N		108.00
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respi ratory 4.00	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"		N	N	N	109.00
for yes or "N" for no for each therapy.					
				1.00	
110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, Lines 200 through 218, and Wo	"Y" for yes o	r "N" for no. I	f yes,	N	110.00
applicable.	N NONCEL E-Z,		iyii 210, as		

Health Financial Systems STARKE MEMORIAL HOSPITAL		In Lieu	of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider (F	eriod: rom 01/01/2020	Worksheet S- Part I	
	T	o 12/31/2020	Date/Time Pr 7/29/2021 3:	epared: 27 pm
		1.00	2.00	_
111.00 If this facility qualifies as a CAH, did it participate in the Frontier of Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional bed for tele-health services.	period? Enter enter the n column 2.	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. Miscellaneous Cost Reporting Information	N			112.00
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			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00 Is the mal practice insurance a claims-made or occurrence policy? Enter 1		1		118.00
if the policy is claim-made. Enter 2 if the policy is occurrence.	Premi ums	Losses	Insurance	
	1.00	2.00	3.00	_
118.01 List amounts of malpractice premiums and paid losses:	4, 774	4 6, 098		0 118. 01
		1.00	2.00	_
118. 02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing and amounts contained therein. 119. 00 ID0 NOT USE THIS LINE		N		118.02
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "" "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see ins Enter in column 2, "Y" for yes or "N" for no.	Y" for yes or the Outpatient	N	Y	120.00
121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no.	es charged to	Y		121.00
122.00 Does the cost report contain healthcare related taxes as defined in §190. Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter 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	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, enter the cert				126.00
in column 1 and termination date, if applicable, in column 2. 127.00 f this is a Medicare certified heart transplant center, enter the certi	fication date			127.00
127. John this is a mean care centified heart transplant center, enter the cent				128.00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certi	fication date			
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certiin column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certified lung transplant center transplan				129.00
 in column 1 and termination date, if applicable, in column 2. 128.00 15 this is a Medicare certified liver transplant center, enter the certific column 1 and termination date, if applicable, in column 2. 129.00 14 this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2. 	ication date in			
 in column 1 and termination date, if applicable, in column 2. 128.00 128.00 15 this is a Medicare certified liver transplant center, enter the certified of the column 1 and termination date, if applicable, in column 2. 129.00 14 this is a Medicare certified lung transplant center, enter the certificolumn 1 and termination date, if applicable, in column 2. 130.00 15 this is a Medicare certified pancreas transplant center, enter the certificate in column 1 and termination date, if applicable, in column 2. 	ication date in rtification			130.00
 in column 1 and termination date, if applicable, in column 2. 128.00 128.00 128.00 129.00 129.00 129.00 129.00 129.00 120.00 <l< td=""><td>ication date in rtification certification</td><td></td><td></td><td>130. 00 131. 00</td></l<>	ication date in rtification certification			130. 00 131. 00
 in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certific or column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certific or umn 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the certified in testinal transplant center, enter the certified in testinal transplant center, enter the certified intestinal transplant center testified intestinal transplant center	ication date in rtification certification fication date			129.00 130.00 131.00 132.00 133.00 134.00

USPITAL AND HUSPITAL HEALTH CARE CUMPLEA	IDENTIFICATION DATA	ORIAL HOSPITAL Provider CO	CN: 15-0102	Peri od:	u of Form CMS Worksheet S	
				From 01/01/2020 To 12/31/2020	Date/Time Pi	
1.00		2.00		3.00	7/29/2021 3:	27 pm
If this facility is part of a chain	n organization, enter		uah 143 the i		of the	-
home office and enter the home off 41.00 Name: CHS/COMMUNITY HEALTH SYSTEM	<u>ice contractor name ar</u>	d contractor numb	er.	or's Number: 5228		141.0
INC		. WIS	Contract	.01 3 Number . 5220	0	141. (
42.00 Street: 4000 MERIDIAN BOULEVARD	PO Box:					142. (
43.00 City: FRANKLIN	State:	TN	Zip Code	3706	57	143. (
					1.00	-
44.00 Are provider based physicians' cos	ts included in Workshe	et A?			Y	144. (
				1.00	2.00	-
45.00 If costs for renal services are cla	aimed on Wkst. A, line	74, are the costs	s for	1.00	2.00	145.
inpatient services only? Enter "Y"						
no, does the dialysis facility incl period? Enter "Y" for yes or "N" t		ion for this cost	reporting			
46.00 Has the cost allocation methodology		viously filed cos [.]	t report?	N		146. (
Enter "Y" for yes or "N" for no in	column 1. (See CMS Pu			-		
yes, enter the approval date (mm/de	d/yyyy) in column 2.					_
					1.00	_
47.00 Was there a change in the statistic					N	147.
48.00 Was there a change in the order of					N	148.
49.00 Was there a change to the simplifie	eu cost finding method	<u>Part A Part A 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 </u>	es or "N" for Part B	Title V	N Title XIX	149. (
		1.00	2.00	3.00	4.00	-
Does this facility contain a provi						
or charges? Enter "Y" for yes or "I	N" for no for each com		and Part B. N	(See 42 CFR §413		155
55.00 Hospital 56.00 Subprovider - IPF		N	N N	N	N N	155. 156.
57.00 Subprovi der – I RF		N	N	N	N	157.
58. 00 SUBPROVI DER						158. (
59. 00 SNF 60. 00 HOME HEALTH AGENCY		N	N N	N	N N	159. (160. (
61. 00 CMHC		IN	N N	N	N	161. 0
61. 10 CORF			N	N	N	161.
					1.00	_
Multicampus					1.00	-
65.00 Is this hospital part of a Multicar	mpus hospital that has	one or more camp	uses in diffe	erent CBSAs?	N	165. (
Enter "Y" for yes or "N" for no.	N	0		0.1.00004		_
	Name 0	<u>County</u> 1.00	State Zi 2.00	p Code CBSA 3.00 4.00	FTE/Campus 5.00	-
66.00 If line 165 is yes, for each			2.00			00 166. (
campus enter the name in column						
0, county in column 1, state in						
column 2 zin code in column 3						
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in						
						_
CBSA in column 4, FTE/Campus in					1.00	_
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT)				nt Act	1.00	_
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 67.00 Is this provider a meaningful user	under §1886(n)? Ente	r "Y" for yes or '	'N" for no.		1.00 Y	
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 105	under §1886(n)? Ente 5 is "Y") and is a mea	r "Y" for yes or ' ningful user (line	'N" for no.		1	
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 109 reasonable cost incurred for the HI	under §1886(n)? Ente 5 is "Y") and is a mea IT assets (see instruc	r "Y" for yes or ' ningful user (line tions)	'N" for no. e 167 is "Y")	, enter the	1	168.
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10! reasonable cost incurred for the HI 68.01 If this provider is a CAH and is no exception under §413.70(a)(6)(ii)?	under §1886(n)? Ente 5 is "Y") and is a mea 1T assets (see instruc ot a meaningful user, Enter "Y" for yes or	r "Y" for yes or ' ningful user (ling tions) does this providen "N" for no. (see i	'N" for no. e 167 is "Y") r qualify for instructions)), enter the - a hardship	Y	168. (168. (
CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 109 reasonable cost incurred for the HI 68.01 If this provider is a CAH and is no exception under §413.70(a)(6)(ii)? 69.00 If this provider is a meaningful user	under §1886(n)? Ente 5 is "Y") and is a mea 1T assets (see instruc 5t a meaningful user, Enter "Y" for yes or ser (line 167 is "Y")	r "Y" for yes or ' ningful user (ling tions) does this providen "N" for no. (see i	'N" for no. e 167 is "Y") r qualify for instructions)), enter the - a hardship	Y	168. (168. (
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 109 reasonable cost incurred for the HI 68.01 If this provider is a CAH and is no exception under §413.70(a)(6)(ii)?	under §1886(n)? Ente 5 is "Y") and is a mea 1T assets (see instruc 5t a meaningful user, Enter "Y" for yes or ser (line 167 is "Y")	r "Y" for yes or ' ningful user (ling tions) does this providen "N" for no. (see i	'N" for no. e 167 is "Y") r qualify for instructions)), enter the - a hardship	Y	168. 168.
CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10) reasonable cost incurred for the HI 68.01 If this provider is a CAH and is no exception under §413.70(a) (6) (ii)? 69.00 If this provider is a meaningful use transition factor. (see instruction	under §1886(n)? Ente 5 is "Y") and is a mea 1T assets (see instruc ot a meaningful user, Enter "Y" for yes or ser (line 167 is "Y") ns)	r "Y" for yes or ' ningful user (lind tions) does this provide "N" for no. (see i and is not a CAH	'N" for no. e 167 is "Y") n qualify for nstructions) (line 105 is	, enter the a hardship "N"), enter the	Y 9.	168. (168. (99169. (
CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10) reasonable cost incurred for the HI 68.01 If this provider is a CAH and is no exception under §413.70(a) (6) (ii)? 69.00 If this provider is a meaningful us transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR be	under §1886(n)? Ente 5 is "Y") and is a mea 1T assets (see instruc ot a meaningful user, Enter "Y" for yes or ser (line 167 is "Y") ns)	r "Y" for yes or ' ningful user (lind tions) does this provide "N" for no. (see i and is not a CAH	'N" for no. e 167 is "Y") n qualify for nstructions) (line 105 is	, enter the a hardship "N"), enter the Beginning	Y 9. Endi ng	168. (168. (99169. (
CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 109 reasonable cost incurred for the HI 68.01 If this provider is a CAH and is no exception under §413.70(a) (6) (ii)? 69.00 If this provider is a meaningful user	under §1886(n)? Ente 5 is "Y") and is a mea 1T assets (see instruc ot a meaningful user, Enter "Y" for yes or ser (line 167 is "Y") ns)	r "Y" for yes or ' ningful user (lind tions) does this provide "N" for no. (see i and is not a CAH	'N" for no. e 167 is "Y") n qualify for nstructions) (line 105 is	, enter the a hardship "N"), enter the Beginning	Y 9. Endi ng	168. (168. (99169. (
CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10) reasonable cost incurred for the HI 68.01 If this provider is a CAH and is no exception under §413.70(a) (6) (ii)? 69.00 If this provider is a meaningful us transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR be	under §1886(n)? Ente 5 is "Y") and is a mea 1T assets (see instruc ot a meaningful user, Enter "Y" for yes or ser (line 167 is "Y") ns)	r "Y" for yes or ' ningful user (lind tions) does this provide "N" for no. (see i and is not a CAH	'N" for no. e 167 is "Y") n qualify for nstructions) (line 105 is	, enter the a hardship "N"), enter the Beginning	Y 9. Endi ng	167. (168. (168. (99169. (170. (
CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10) reasonable cost incurred for the HI 68.01 If this provider is a CAH and is no exception under §413.70(a) (6) (ii)? 69.00 If this provider is a meaningful us transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR be	under §1886(n)? Ente 5 is "Y") and is a mea 1T assets (see instruc ot a meaningful user, Enter "Y" for yes or ser (line 167 is "Y") ns) eginning date and endi ider have any days for	r "Y" for yes or ' ningful user (lind tions) does this provided "N" for no. (see i and is not a CAH ng date for the ro individuals enrol	'N" for no. e 167 is "Y") r qualify for instructions) (line 105 is eporting	, enter the a hardship "N"), enter the Beginning 1.00	Y 9. <u>Endi ng</u> 2. 00	168. (168. (99169. (

IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0102	Period: From 01/01/2020	Worksheet S Part II	
				To 12/31/2020	Date/Time F 7/29/2021 3	
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	snonses Ent	1.00	2.00	
	mm/dd/yyyy format.		Sponses. Ent		ine	
	COMPLETED BY ALL HOSPITALS					
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	bogi ppi pg. of	the cost	N		1.
. 00	reporting period? If yes, enter the date of the change in co					1.1
			Y/N	Date	V/I	
		0.1.6	1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2.
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	ffices, drug er or its f the board	Y			3. (
			Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi	fied Dublie	Y	A		4.
	Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	or Compiled, ilable in		~		
. 00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit reco		N			5.
				Y/N	Legal Oper.	
				1.00	2.00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	1.6		- N		
. 00	the legal operator of the program?	TT yes, is tr	le provider i	s N		6.
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing school and/or allied health programs approved a		during the	N N		7. 8.
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved g		cal education	N		9.
0. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.		the current	Ν		10.
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	Y/N	11.
					1.00	
2	Bad Debts	ooo irret	ti ano		V	10
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			ost reporting	Y N	12. 13.
	If line 12 is yes, were patient deductibles and/or co-paymer Bed Complement		*		N	14.
5.00	Did total beds available change from the prior cost reportin	<u> </u>	yes, see ins ⁻ t A		Y t B	15.
	-	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only?	Y	04/14/2021	Y	04/14/2021	16.
5. 00	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)	·	04/16/2021		04/16/2021	10.
7.00	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	Ν		Ν		17.
8. 00	in columns 2 and 4. (see instructions) 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	Ν		Ν		18.
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19.

ISPI TA	Financial Systems STARKE MEMORI. L AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	N: 15-0102	Peri od: From 01/01/2020 To 12/31/2020	u of Form CMS Worksheet S- Part II Date/Time Pr 7/29/2021 3:	-2 repare	
		Descri	ption	Y/N	Y/N		
		C		1.00	3.00		
0.00	If line 16 or 17 is yes, were adjustments made to PS&R			N	N	20	
	Report data for Other? Describe the other adjustments:						
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
00 V	Was the cost report prepared only using the provider's	N		N		21	
r	records? If yes, see instructions.						
					1.00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS HO	JSPI TALS)			_	
	Capital Related Cost						
	Have assets been relifed for Medicare purposes? If yes, see				N	22	
	Have changes occurred in the Medicare depreciation expense	due to apprais	als made dur	ring the cost	N	23	
	reporting period? If yes, see instructions.						
	Were new leases and/or amendments to existing leases entered into during this cost reporting period?						
	If yes, see instructions						
	Have there been new capitalized leases entered into during	the cost report	ting period?	?lfyes, see	N	2!	
	instructions.						
	Were assets subject to Sec.2314 of DEFRA acquired during th	ne cost reporti	ng period? I	t yes, see	N	2	
	instructions.						
	Has the provider's capitalization policy changed during the	e cost reporting	ן period? If	r yes, submit	N	2	
	copy.					_	
	nterest Expense				••	_	
	Nere new loans, mortgage agreements or letters of credit en	itered into dur	ing the cost	t reporting	N	28	
	period? If yes, see instructions.						
						2	
	treated as a funded depreciation account? If yes, see instructions						
	5 1 1 5						
	instructions.	c					
	Has debt been recalled before scheduled maturity without is	suance of new o	Jept? IT yes	s, see	N	3	
	i nstructi ons.						
	Purchased Services Have changes or new agreements occurred in patient care ser	ulara Gundaha	-		N	-	
	arrangements with suppliers of services? If yes, see instru			JITTI actual	N	32	
	If line 32 is yes, were the requirements of Sec. 2135.2 app		a to competi	tive bidding? If	Ν	33	
	no, see instructions.		j to competi	tive broaring: IT	IN IN		
	Provi der-Based Physi ci ans						
	Are services furnished at the provider facility under an ar	rangement with	nrovi der-bi	asod physicians?	Y	34	
	If yes, see instructions.	rangement with	provider-ba	ased physicians:	I I	.	
	If line 34 is yes, were there new agreements or amended exi	sting agreemen	ts with the	nrovi der-based	Ν	35	
	physicians during the cost reporting period? If yes, see in		ts with the	pi ovi dei -based	IN IN	.	
1	physicians during the cost reporting period: in yes, see in			Y/N	Date		
				1.00	2.00		
H	Home Office Costs						
	Were home office costs claimed on the cost report?			Y		30	
	If line 36 is yes, has a home office cost statement been pr	repared by the	nome office			3	
	If yes, see instructions.						
	If line 36 is yes, was the fiscal year end of the home off	ice different	from that of	F Y	12/31/2019	38	
	the provider? If yes, enter in column 2 the fiscal year end						
	If line 36 is yes, did the provider render services to othe			s, N		30	
	see instructions.		2				
	If line 36 is yes, did the provider render services to the	home office?	If yes, see	Ν		40	
	instructions.						
		1. (00	2.	00		
С	Cost Report Preparer Contact Information						
		MI CHAEL		TEA		41	
ł	held by the cost report preparer in columns 1, 2, and 3,						
	respectively.						
I	1 5	COMMUNITY HEAL	TH SYSTEMS			42	
		COMMUNITY HEALTH SYSTEMS				11	
00 E	preparer.						
00	preparer.	615-628-6555		MI CHAEL_TEA@CHS	S. NET	43	

Heal th	Financial Systems	STARKE MEMORIA	L HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 15-0102	Period:	Worksheet S-2	
					From 01/01/2020 To 12/31/2020		
				3.00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the t	title/position S	R MANAGER -	· REV MGT			41.00
	held by the cost report preparer in colur	nns 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the co	ost report					42.00
	preparer.						
43.00	Enter the telephone number and email addr	ress of the cost					43.00
	report preparer in columns 1 and 2, respe	ecti vel y.					

	Financial Systems	STARKE MEMORIA		N. 1E 0100	Dom!!	In Lie	u of Form CMS-2	
HUSPII	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	N: 15-0102	Period: From 01	/01/2020	Worksheet S-3 Part I	
						2/31/2020	Date/Time Pre 7/29/2021 3:2	
							I/P Days / O/P	
	Component	Worksheet A	No. of Beds	Bed Days	CAL	Hours	<u>Visits / Trips</u> Title V	
	component	Line Number	NO. OI DEUS	Avai I abl e	CAI	nour s	nue v	
		1.00	2.00	3.00	4	1.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	14	5, 1	24	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
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		14	5, 1	24	0.00	0	7.00
8.00	beds) (see instructions) INTENSIVE CARE UNIT	31.00	1	2	66	0.00	0	8.00
9.00	CORONARY CARE UNIT	31.00	'	5	00	0.00	0	9,00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43.00					0	13.00
14.00	Total (see instructions)		15	5, 4	90	0.00	0	14.00
15.00	CAH visits	10.00					0	15.00
16.00 17.00	SUBPROVIDER - IPF	40.00 41.00	0		0		0	16.00 17.00
17.00	SUBPROVI DER – I RF SUBPROVI DER	41.00	0		0		0	17.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
22.00	HOME HEALTH AGENCY	101.00					0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115.00						23.00
24.00	HOSPICE	116.00	0		0			24.00
24.10	HOSPICE (non-distinct part)	30.00					0	24.10
25.00 25.10	CMHC – CMHC CMHC – CORF	99. 00 99. 10					0	25.00 25.10
26.00	RURAL HEALTH CLINIC	88.00					0	25.10
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00					0	26.25
27.00	Total (sum of lines 14-26)	07100	15				Ū	27.00
28.00	Observation Bed Days		-				0	28.00
29.00	Ambul ance 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
	LTCH site neutral days and discharges							33.01

IOSPI T	FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	<u>7/29/2021 3:2</u> Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 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)	674	47	1, 52	0		1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider	291 0	284 0				2.00 3.00
1.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF	0	0		0		4.00 5.00
o. 00	Hospital Adults & Peds. Swing Bed NF	-	0		0		6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	674	47	1, 52			7.00
 00 00 00 00 00 00 	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T	0	0		0		8.00 9.00 10.00 11.00
2.00 3.00	OTHER SPECIAL CARE (SPECIFY) NURSERY		0		o		12.00 13.00
4.00 5.00	Total (see instructions) CAH visits	674 0	47	1, 52	0 0.00 0	107.18	14.00 15.00
6.00	SUBPROVIDER - IPF	0	0		0 0.00		16.00
7.00 8.00 9.00 0.00 1.00	SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0	0				18.00 19.00 20.00 21.00
2.00 3.00 4.00 4.10	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part)	0 0	0		0 0.00 0.00 0 0.00	0.00	23.00
5.00 5.10 6.00	CMHC - CMHC CMHC - CORF RURAL HEALTH CLINIC	0 0 0	0 0 0		0 0.00 0 0.00 0 0.00 0 0.00	0.00	25. 00 25. 10
6. 25 7. 00 8. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days	0	0		0 0.00 0.00 4		
9.00 0.00 1.00	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF	0			0		29.00 30.00 31.00
2. 00 2. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0	0		0		32. 0 32. 0
3. 00 3. 01	LTCH non-covered days LTCH site neutral days and discharges	0 0					33. 0 33. 0

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	STARKE MEMORIAL AL DATA	Provider CC	CN: 15-0102	Period: From 01/01/2020 To 12/31/2020	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre 7/29/2021 3:2	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	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) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSI VE CARE UNIT SURGICAL INTENSI VE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits	0.00	0	1:	14.00 11.00 100 54 0 0 0 81 100	15.00 445 445	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00
16.00 17.00 18.00 19.00 20.00 21.00 22.00 24.00 24.00 25.10 25.00 25.10 26.00 25.10 26.25 27.00 28.00 29.00 30.00 31.00 32.01 33.00	SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC CMHC - CORF RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	0 0			0 0	16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.10 25.00 25.10 26.00 25.10 26.25 27.00 28.00 29.00 30.00 31.00 32.01 33.00 33.01

PI T.	Financial Systems AL WAGE INDEX INFORMATION		STARKE MEMORI	Provider CC		eriod: rom 01/01/2020	Date/Time Pre	pare
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Related to Salaries in col. 4	7/29/2021 3:2 Average Hourly Wage (col. 4 ÷ col. 5)	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARI ES							
0	Total salaries (see	200.00	6, 484, 450	0	6, 484, 450	222, 942. 00	29.09	1.
0	instructions) Non-physician anesthetist Part		C	0	0	0.00	0.00	2
~	A				0	0.00	0.00	
0	Non-physician anesthetist Part B		Ĺ	0	0	0.00	0.00	3
0	Physician-Part A -		C	0	0	0.00	0.00	4
1	Administrative Physicians - Part A - Teaching		C	0	0	0.00	0.00	4
0	Physician and Non		C	0	0	0.00		
0	Physician-Part B Non-physician-Part B for		C	0	0	0.00	0. 00	6
0	hospital-based RHC and FQHC			Ŭ	0	0.00	0100	
0	services Interns & residents (in an	21.00	ſ	0	0	0.00	0. 00	7
	approved program)	21.00	C		-			
1	Contracted interns and residents (in an approved		C	0	0	0.00	0.00	7
	programs)							
0	Home office and/or related		C	0	0	0.00	0.00	8
0	organization personnel SNF	44.00	C	0	0	0.00	0.00	Ģ
00	Excluded area salaries (see		C	0	0	0.00	0.00	10
	instructions) OTHER WAGES & RELATED COSTS							
00	Contract Labor: Direct Patient		C	0	0	0.00	0.00	11
00	Care Contract Labor: Top Level		2, 661	0	2, 661	19.00	140. 05	11
00	management and other management and administrative		2,001	0	2,001	17.00	140.00	
00	services Contract Labor: Physician-Part		C	0	0	0.00	0. 00	13
00	A - Administrative Home office and/or related		C	0	0	0.00	0. 00	1/
00	organization salaries and		C C	0	0	0.00	0.00	'`
01	wage-related costs Home office salaries		610, 378	0	610, 378	18, 246. 00	33. 45	1
02	Related organization salaries		010, 378 C	1	010, 378	0.00		
00	Home office: Physician Part A		C	0	0	0.00	0.00	15
00	- Administrative Home office and Contract		C	0	0	0.00	0.00	16
~ 1	Physicians Part A - Teaching				0	0.00	0.00	
01	Home office Physicians Part A - Teaching		l	0	0	0.00	0.00	16
02	Home office contract		C	0	0	0.00	0.00	16
	Physicians Part A - Teaching WAGE-RELATED COSTS			<u> </u>				-
	Wage-related costs (core) (see		1, 385, 927	0	1, 385, 927			17
00	instructions) Wage-related costs (other)							18
	(see instructions)							
00 00	Excluded areas Non-physician anesthetist Part		0	0	0			19
00	A		Ĺ		0			20
00	Non-physician anesthetist Part B		C	0	0			21
00	Physician Part A -		C	0	0			22
01	Administrative Physician Part A - Teaching		r	0	Ω			22
00	Physician Part B		C	0	0			23
00 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		C	0	0			24 25
00	approved program)		Ĺ		0			20
50	Home office wage-related		130, 926	0	130, 926			25
51	(core) Related organization		C	0	0			25
	wage-related (core)		-		-			
	Home office: Physician Part A - Administrative - wage-related (core)		C	0	0			25

Heal th	Financial Systems		STARKE MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provi der CCN: 15-0102		Period: From 01/01/2020 To 12/31/2020		
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		0		25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARI							
26.00	Employee Benefits Department	4.00			76, 57			
27.00	Administrative & General	5.00	978, 361	-100, 843	877, 51	8 36, 694. 00	23. 91	27.00
28.00	Administrative & General under		985	0	98	5 21.00	46.90	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0 0.00		29.00
30.00	Operation of Plant	7.00	422, 463	0	422, 46	3 18, 978. 00	22.26	30.00
31.00	Laundry & Linen Service	8.00	0	0		0 0.00		31.00
32.00	Housekeepi ng	9.00	217, 100	0	217, 10	0 14, 012. 00	15. 49	32.00
33.00	Housekeeping under contract		56, 730	0	56, 73	0 1, 719. 00	33.00	33.00
	(see instructions)							
34.00	Dietary	10.00	176, 886	-128, 889	47, 99	7 2, 833.00	16. 94	34.00
35.00	Dietary under contract (see		0	0		0 0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11.00	0	128, 889	128, 88			36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	37.00
38.00	Nursing Administration	13.00	133, 520	100, 843	234, 36	3 4, 251. 00	55. 13	38.00
39.00	Central Services and Supply	14.00	71, 558	0	71, 55	8 3, 573.00	20. 03	39.00
40.00	Pharmacy	15.00	237, 385	0	237, 38	5 5, 507.00	43. 11	40.00
41.00	Medical Records & Medical	16.00	53, 171	0	53, 17	1 3, 188. 00	16.68	41.00
	Records Library							
42.00	Social Service	17.00	25, 659	0	25, 65	9 618.00	41. 52	42.00
43.00	Other General Service	18.00	0	0		0 0.00	0.00	43.00

Heal th	Financial Systems		STARKE MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2020	Worksheet S-3 Part III	
						To 12/31/2020	Date/Time Prep 7/29/2021 3:2	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		6, 542, 165	0	6, 542, 16	5 224, 682. 00	29. 12	1.00
	instructions)							
2.00	Excluded area salaries (see		0	0		0.00	0.00	2.00
	instructions)							
3.00	Subtotal salaries (line 1		6, 542, 165	0	6, 542, 16	5 224, 682. 00	29. 12	3.00
	minus line 2)							
4.00	Subtotal other wages & related		613, 039	0	613, 03	9 18, 265. 00	33. 56	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		1, 516, 853	0	1, 516, 85	3 0.00	23. 19	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		8, 672, 057	0	8, 672, 05	7 242, 947. 00	35. 70	6.00
7.00	Total overhead cost (see		2, 450, 392	0	2, 450, 39	2 101, 302. 00	24.19	7.00
	instructions)							

Heal th	Financial Systems	STARKE MEMORIAL	HOSPI TAL				In L	ieu of Form CM	S-25	52-10
	AL WAGE RELATED COSTS		Provi der	CCN:	15-0102	Peri From To		Worksheet S 20 Part IV	i-3 Prepa	ared:
								Amount		
								Reported		
								1.00		
	PART IV - WAGE RELATED COSTS Part A - Core List									
	RETIREMENT COST									
1.00	401K Employer Contributions							76, 6	62	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribu	ition						70,0	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see i								0	2.00 3.00
4.00	Qualified Defined Benefit Plan Cost (see inst								0	4.00
4.00	PLAN ADMINISTRATIVE COSTS (Paid to External C								-	4.00
5.00	401K/TSA Plan Administration fees								0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	n							0	6.00
7.00	Employee Managed Care Program Administration								0	7.00
	HEALTH AND INSURANCE COST								-	
8.00	Heal th Insurance (Purchased or Self Funded)								0	8.00
8.01	Heal th Insurance (Self Funded without a Third	d Party Administra	ator)						õ	8.01
8.02	Health Insurance (Self Funded with a Third Pa							718, 7	61	8.02
8.03	Heal th Insurance (Purchased)		,						0	8.03
9.00	Prescription Drug Plan								0	9.00
10.00	Dental, Hearing and Vision Plan							17, 8	46	10.00
11.00	Life Insurance (If employee is owner or bener	fi ci arv)								11.00
12.00	Accident Insurance (If employee is owner or I							6	28	12.00
13.00	Disability Insurance (If employee is owner or	r beneficiary)						13, 7	39	13.00
14.00	Long-Term Care Insurance (If employee is owned	er or beneficiary)						0	14.00
15.00	'Workers' Compensation Insurance	5.						90, 1	66	15.00
16.00	Retirement Health Care Cost (Only current year	ar, not the extra	ordinary ad	ccrua	I require	ed by	FASB 106.		0	16.00
	Non cumulative portion)									
	TAXES									
17.00	FICA-Employers Portion Only							360, 7		
18.00	Medicare Taxes - Employers Portion Only							84, 3	62	18.00
19.00	Unemployment Insurance								0	19.00
20.00	State or Federal Unemployment Taxes							19, 5	24	20.00
	OTHER							1		
21.00	Executive Deferred Compensation (Other Than I instructions))	Retirement Cost Re	eported on	line	s 1 throu	ugh 4	above. (se	e	0	21.00
22.00	Day Care Cost and Allowances									22.00
23.00	Tuition Reimbursement									23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)							1, 385, 9	25	24.00
	Part B - Other than Core Related Cost							_		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)							I		25.00

Health Financial Systems	STARKE MEMORIAL HOSPITAL	In Lieu	of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0102	Peri od:	Worksheet S-3	
			Part V	
		To 12/31/2020	Date/Time Pre 7/29/2021 3:2	
Cost Center Description		Contract Labor	Benefit Cost	/ piii
cost center bescription		1.00	2.00	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Ide	nti fi cati on:			
1.00 Total facility's contract labor and benef		0	1, 385, 925	1.00
2.00 Hospital		0	1, 385, 925	
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				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		0	0	12.00
13.00 Hospital-Based Hospice		0	0	13.00
14.00 Hospital-Based Health Clinic RHC		0	0	14.00
15.00 Hospital-Based Health Clinic FQHC		0	0	15.00
16.00 Hospital-Based-CMHC		0	0	16.00
16.10 Hospital-Based-CMHC 10		0	0	
17.00 Renal Dialysis		0	0	
18.00 Other		0	0	18.00

Heal th	Financial Systems STARKE MEMORIAL H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
		Provider CCN: 15-010		eriod:	Worksheet S-1	0
			T	rom 01/01/2020 o 12/31/2020	Date/Time Pre 7/29/2021 3:2	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	vided by line 202 co	olumn 8	3)	0. 186897	1.00
	Medicaid (see instructions for each line)			- /		1
2.00	Net revenue from Medicaid				1, 119, 283	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement		edi cai o	d?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	rom Medicaid			0	
6.00	Medicaid charges				18, 699, 614	
7.00	Medicaid cost (line 1 times line 6)				3, 494, 902	
8.00	Difference between net revenue and costs for Medicaid program (< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions fo		- Tines	s 2 and 5; IT	2, 375, 619	8.00
9.00	Net revenue from stand-al one CHIP				0	9.00
10.00					0	
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line	9; if	< zero then	0	
	enter zero)	•	-			
	Other state or local government indigent care program (see inst					
13.00	Net revenue from state or local indigent care program (Not incl				0	
14.00	Charges for patients covered under state or local indigent care 10)	e program (Not inclu	uded in	n lines 6 or	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 inc		(line	15 minus line	0	16.00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)	P and state/local i	ndi ger	nt care program	ns (see	
17.00	Private grants, donations, or endowment income restricted to fu	unding charity care			0	
18.00	Government grants, appropriations or transfers for support of h				0	
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	indigent care prog	grams	(sum of lines	2, 375, 619	19.00
		Uni nsu		Insured	Total (col. 1	
		patier		patients	+ col . 2)	
	Uncompensated Care (see instructions for each line)	1.00)	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the entire fac	cility 83	36, 153	0	836, 153	20.00
	(see instructions)					
21.00	Cost of patients approved for charity care and uninsured discou instructions)	ints (see 15	56, 274	0	156, 274	21.00
22.00	Payments received from patients for amounts previously written	off as	0	0	0	22.00
22.00	charity care	1		0	15/ 074	22.00
23.00	Cost of charity care (line 21 minus line 22)		56, 274	0	156, 274	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patier		ngth of	f stay limit	N	24.00
25.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond th		ogram's	s length of	0	25.00
26 00	stay limit Total bad debt expense for the entire hospital complex (see ins	tructions)			1, 123, 985	26.00
27.00					63, 620	
	Medicare allowable bad debts for the entire hospital complex (s				97,877	
28.00					1, 026, 108	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see instructi	ons)		226, 034	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				382, 308	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			2, 757, 927	31.00

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provider CO		eriod: rom 01/01/2020	Worksheet A	2552-10
					o 12/31/2020	Date/Time Pre 7/29/2021 3:2	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		-40, 575	-40, 575	270, 290	229, 715	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		576, 397	576, 397		648, 256	2.00
	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	76, 574	0 7, 666	0 84, 240	0 922, 459	0 1, 006, 699	
	00500 ADMI NI STRATI VE & GENERAL	978, 361	149, 534			-157, 610	
	00700 OPERATION OF PLANT	422, 463	836, 623			1, 694, 751	
	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0 217, 100	54, 537 149, 985	54, 537 367, 085		54, 537 367, 037	
10.00	01000 DI ETARY	176, 886	140, 199	317, 085	-241, 314	75, 771	10.00
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0 133, 520	0 13, 856	0 147, 376	238, 871 100, 749	238, 871 248, 125	
	01400 CENTRAL SERVICES & SUPPLY	71, 558	121, 336			151, 447	
	01500 PHARMACY	237, 385	459, 881	697, 266		264, 374	
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	53, 171 25, 659	87, 332 1, 917	140, 503 27, 576		140, 440 27, 576	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	878, 809 0	485, 921 0	1, 364, 730	-3, 377	1, 361, 353 0	
	04000 SUBPROVIDER - IPF	0	0		0	0	
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	
	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	43.00
	05000 OPERATI NG ROOM	367, 865	205, 299	573, 164	-39, 831	533, 333	50.00
	05100 RECOVERY ROOM	0	0	0	0	0	
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0 190, 942	190, 942	0 -1, 784	0 189, 158	
	05400 RADI OLOGY-DI AGNOSTI C	451, 322	270, 638			588, 491	
	05401 ULTRASOUND	70, 228	28, 467	98, 695	-17, 696		
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0 10, 013	46, 364	56, 377	-22, 581	0 33, 796	
57.00	05700 CT SCAN	49, 759	117, 337			73, 795	
		16, 884	68, 636	85, 520	-66, 727	18, 793	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	541, 787	0 443, 184	984, 971	-57, 932	0 927, 039	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 311, 177	0 31, 039	0 342, 216	0 -3, 245	0 338, 971	
	06600 PHYSI CAL THERAPY	226, 879	44, 487			374,066	
	06700 OCCUPATI ONAL THERAPY	68, 197	5, 703			0	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	25, 067 108, 378	4, 040 11, 856			0 120, 234	
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	120, 234	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	9, 519	9, 519	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		23, 004 374, 352	23, 004 374, 352	
	07400 RENAL DI ALYSI S	0	0	0	0	0	
	07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0	
+	03030 ANGI OCARDI OGRAPHY OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76.00
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 -315	0 471, 552	0 471, 237	0 - 466	0 470, 771	89.00 90.00
	09100 EMERGENCY	965, 723	1, 723, 656				
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1					92.00
	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
95.00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD 09900 CMHC	0	0		0	0	
99. 10	09910 CORF	0	0	0	0	0	99.10
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0		100.00
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	U	0	0	0	0	101.00
105.00	10500 KIDNEY ACQUISITION	0	0	0	0		105.00
	10600 HEART ACQUISITION 10700 LIVER ACQUISITION	0	0		0		106.00 107.00
	10800 LUNG ACQUISITION	0	0	0	0		108.00
108.00		1	0			í – – – – – – – – – – – – – – – – – – –	1100 00
109.00	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION	0	0	0	0		109.00 110.00

Health Financial Systems	STARKE MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC		Period:	Worksheet A	
				rom 01/01/2020 o 12/31/2020	Date/Time Pre 7/29/2021 3:2	
Cost Center Description	Sal ari es	Other		Recl assi fi cati		
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00	0.00	2.00	1.00	col . 4)	
	1.00	2.00	3.00	4.00	5.00	110.00
113.00 11300 INTEREST EXPENSE		0	(0		113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0	C	0 0		114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	C	0 0		115.00
116. 00 11600 HOSPI CE	0	0	(0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 484, 450	6, 707, 809	13, 192, 259	0	13, 192, 259	118.00
NONREI MBURSABLE COST CENTERS	· · · · · ·		-	1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0 0		190.00
191. 00 19100 RESEARCH	0	0	0	0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	-36, 144	-36, 144	l 0	-36, 144	192.00
193.00 19300 NONPALD WORKERS	0	0	0	0 0	0	193.00
194.00 07950 SPECIALTY CLINICS / MOB	0	0	0	0 0	0	194.00
200.00 TOTAL (SUM OF LINES 118 through 199)	6, 484, 450	6, 671, 665	13, 156, 115	ō 0	13, 156, 115	200. 00

	Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (STARKE MEMORI DF EXPENSES	AL HOSPITAL Provider CC	Fr	eriod: com 01/01/2020		
				To	12/31/2020	Date/Time Pre 7/29/2021 3:2	
	Cost Center Description	Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	71,032					1.00
2.00 3.00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS	-48, 938					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	3, 973, 261	.,				5.00
7.00	00700 OPERATION OF PLANT	C					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	C					8.00
9.00	00900 HOUSEKEEPING	C					9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	-71, 308					10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-32, 497					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-52,477					14.00
15.00	01500 PHARMACY	C					15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-1, 223	139, 217				16.00
17.00	01700 SOCIAL SERVICE	C	27, 576				17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	2(0.04)	000 007				
30.00 31.00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	-369, 316					30.00
40.00	04000 SUBPROVIDER - IPF						40.00
41.00	04100 SUBPROVI DER – I RF	0					41.00
43.00	04300 NURSERY	C					43.00
	ANCI LLARY SERVICE COST CENTERS	1	1				
50.00	05000 OPERATING ROOM	C					50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM						51.00 52.00
52.00	05300 ANESTHESI OLOGY	-188, 333					53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-237					54.00
54.01	05401 ULTRASOUND	C					54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	C	-				55.00
56.00	05600 RADI OI SOTOPE	C	00,,,0				56.00
57.00 58.00	05700 CT SCAN 05800 MRI						57.00 58.00
58.00 59.00	05900 CARDI AC CATHETERI ZATI ON						59.00
60.00	06000 LABORATORY	-27,000					60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C					62.00
64.00	06400 INTRAVENOUS THERAPY	C					64.00
65.00	06500 RESPI RATORY THERAPY	C	338, 971				65.00
66.00	06600 PHYSI CAL THERAPY		374, 066				66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY		-				67.00 68.00
69.00	06900 ELECTROCARDI OLOGY		120, 234				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	C					70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	.,				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	-11, 852					72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	-7, 411					73.00
75.00	07500 ASC (NON-DI STINCT PART)						75.00
76.00	03030 ANGI OCARDI OGRAPHY						76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	C	1				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	470 771					89.00
90.00 91.00	09000 CLI NI C 09100 EMERGENCY	-470, 771 -1, 537, 968					90.00 91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	-1, 557, 900	1, 140, 020				92.00
2.00	OTHER REIMBURSABLE COST CENTERS	·					
94.00	09400 HOME PROGRAM DI ALYSI S	C					94.00
95.00	09500 AMBULANCE SERVICES	C	0				95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		0				96.00
97.00 99.00	09700 DURABLE MEDICAL EQUIP-SOLD 09900 CMHC						97.00 99.00
99.10			0				99.10
	10000 I &R SERVICES-NOT APPRVD PRGM						100.00
101.00	10100 HOME HEALTH AGENCY	C	0				101.00
405 -	SPECIAL PURPOSE COST CENTERS	1	1				105
	10500 KIDNEY ACQUISITION						105.00 106.00
) 10600 HEART ACQUI SI TI ON) 10700 LI VER ACQUI SI TI ON						106.00
	10800 LUNG ACQUISITION		0				107.00
	10900 PANCREAS ACQUISITION		0				109.00
110.00	11000 INTESTINAL ACQUISITION	C	0				110.00
	11100 I SLET ACQUI SI TI ON	C	0				111.00
	11300 INTEREST EXPENSE	0	-				113.00
114.00	0 11400 UTI LI ZATI ON REVI EW-SNF	<u> </u>	0				114.00

Health Financial Systems	STARKE MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15-0102	Peri od:	Worksheet A
			From 01/01/2020 To 12/31/2020	Date/Time Prepared: 7/29/2021 3:27 pm
Cost Center Description		let Expenses		
	<i>ć</i>	or Allocation		
	6.00	7.00		
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		115.00
116. 00 11600 HOSPI CE	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 277, 439	14, 469, 698		118.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191. 00 19100 RESEARCH	0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	36, 144	0		192.00
193.00 19300 NONPALD WORKERS	0	o		193.00
194.0007950 SPECIALTY CLINICS / MOB	0	0		194.00
200.00 TOTAL (SUM OF LINES 118 through 199)	1, 313, 583	14, 469, 698		200.00

	Financial Systems		STARKE MEMORIA	Provider CCN: 15-0102		u of Form CMS-2552- Worksheet A-6
.A33	SIFICATIONS			Provider CCN. 15-0102	From 01/01/2020	
					To 12/31/2020	Date/Time Prepared 7/29/2021 3:27 pm
		Increases				··· -·· -·· -· -· -· -· -· -· -·
	Cost Center	Line #	Salary	Other		
_	2.00 A - EMPLOYEE BENEFITS	3.00	4.00	5.00		
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	922, 459		1. (
	0		0	922, 459		
	B - RENTAL & LEASE EXPENSES	1 00	0	07.020		1
	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1.00 2.00	0	97, 830 69, 292		1.0
)	WINEE COOLD MUBEE EGOIT	0.00	0	0		3.
)		0.00	0	0		4.0
)		0.00	0	0		5. (
)		0.00 0.00	0	0		6. (
,	0	0.00	— — — <u>o</u>	167, 122		7.0
	C - OTHER CAPITAL COSTS			· · · · ·		
	CAP REL COSTS-BLDG & FIXT	1.00	0	54, 604		1. (
	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1.00 2.00	0	117, 856 2, 567		2. (
		2.00	— — — 0	175,027		5.0
ĺ	D - REPAIRS/MAINTENANCE COST					
	OPERATION OF PLANT	7.00	0	448, 683		1.0
)		0. 00 0. 00	0	0		2. (
)		0.00	0	0		4. (
)		0.00	0	0		5.0
)		0.00	0	0		6.
)		0.00	0	0		7.0
)		0.00 0.00	0	0		8. (
0		0.00	0	Ö		10.0
0		0.00	0	0		11. (
0		0.00	0	0		12. (
)0)0		0.00 0.00	0	0		13. (
0		0.00	0	0		14.
0		0.00	0	0		16.
0		0.00	0	0		17. (
00		0.00	0	0		20.0
0	<u> </u>			00000		21.0
	E - NURSING SALARIES		0	110,000		
)	NURSING ADMINISTRATION	13.00	100, 843	— — <u>0</u>		1. (
			100, 843	0		
	F - MEDICAL SUPPLIES OPERATING ROOM	50,00	0	4,040		1.(
	MEDICAL SUPPLIES CHARGED TO	71.00	0	9, 519		2. (
	PATIENT					
	IMPL. DEV. CHARGED TO	72.00	0	23, 004		3. (
	PATI ENTS	+	— —			
	G - COST OF DRUGS					
)	DRUGS_CHARGED_TO_PATIENTS	73.00	0	374, 352		1. (
			0	374, 352		
	H - PT, ST, AND OT PHYSICAL THERAPY	66.00	93, 264	9, 743		1.0
)		0.00	0	9, 743		2.0
	0 — — — — — —		93, 264	9,743		
	I - DIETARY COSTS			100.005		
)		<u> </u>	128,889	<u>109, 982</u> 109, 982		1.0
	Grand Total: Increases		128, 889 322, 996	2, 243, 931		500.0

	SI FI CATI ONS			1	CCN: 15-0102	Period: From 01/01/2020	Worksheet A-6
						To 12/31/2020	Date/Time Prepare 7/29/2021 3:27 pm
		Decreases					1/29/2021 3.27 pm
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref		
	6.00	7.00	8.00	9.00	10.00	·	
	A - EMPLOYEE BENEFITS	7.00	0.00	7.00	10.00		
00	ADMI NI STRATI VE & GENERAL	5.00	0	922, 459		0	1.
00	ADMINISTRATIVE & GENERAL		0	922, 459		o	1.
	B - RENTAL & LEASE EXPENSES		U	922, 439			
		5.00		02 110		ol	1
00	ADMI NI STRATI VE & GENERAL	5.00	0	82, 119		9	1.
00	OPERATION OF PLANT	7.00	0	13, 018		9	2.
00	CENTRAL SERVICES & SUPPLY	14.00	0	3, 854		0	3.
00	PHARMACY	15.00	0	49, 579		0	4.
00	ADULTS & PEDIATRICS	30.00	0	811		0	5.
00	LABORATORY	60.00	0	14, 496		o	6.
00	RESPIRATORY_THERAPY		0	3, 245		o	7.
	0		0	167, 122			
	C – OTHER CAPITAL COSTS						
00	ADMI NI STRATI VE & GENERAL	5.00	0	175, 027	1	2	1.
00		0.00	0	0		3	2.
00		0.00	0	0	1		3.
-				175, 027	— — — .	1	
	D - REPAIRS/MAINTENANCE COST	I		1101021	<u> </u>		
00	ADMI NI STRATI VE & GENERAL	5.00	0	5, 057		0	1.
00	HOUSEKEEPI NG	9.00	0	48		0	2.
00	DI ETARY	10.00	0	2, 443		0	3.
			0	2, 443 94		0	3.
00	NURSING ADMINISTRATION	13.00	0			-	
00	CENTRAL SERVICES & SUPPLY	14.00	0	1,030		0	5.
00	PHARMACY	15.00	0	8, 961		0	6.
00	MEDI CAL RECORDS & LI BRARY	16.00	0	63		0	7.
	ADULTS & PEDIATRICS	30.00	0	2, 566		0	8.
00	OPERATING ROOM	50.00	0	43, 871		0	9.
00	ANESTHESI OLOGY	53.00	0	1, 784		0	10.
00	RADI OLOGY-DI AGNOSTI C	54.00	0	133, 469		0	11.
00	ULTRASOUND	54.01	0	17, 696		0	12.
. 00	RADI OI SOTOPE	56.00	0	22, 581		0	13.
00	CT SCAN	57.00	0	93, 301		o	14.
	MRI	58.00	o	66, 727		ol	15.
00	LABORATORY	60.00	0	43, 436		0	16.
	PHYSI CAL THERAPY	66.00	0	307		0	17.
	CLINIC	90.00	0	466		o	20.
	EMERGENCY	91.00	0	4, 783		o	20.
00			0	448, 683		4	21.
	E - NURSING SALARIES		0	440,003			
00	ADMI NI STRATI VE & GENERAL	5.00	100, 843	0		0	1.
0			100, 843	0		9	1.
			100, 643	0			
	F - MEDI CAL SUPPLI ES	11.00		0/ 5/0			
00	CENTRAL SERVICES & SUPPLY	14.00	0	36, 563		0	1.
00		0.00	0	0		0	2.
00	<u> </u>	0.00	0	0		ol	3.
	0		0	36, 563			
	G - COST OF DRUGS		,				
00	PHARMACY		<u>0</u>	37 <u>4, 3</u> 52	L	이	1.
	0		0	374, 352			
	H - PT, ST, AND OT						
00	OCCUPATI ONAL THERAPY	67.00	68, 197	5, 703		0	1.
00	SPEECH PATHOLOGY	68.00	25, 067	4, 040		0	2.
-			93, 264	9,743		1	
	I - DIETARY COSTS		, 5, 20 1	,,,,,,,		1	
00	DI ETARY	10.00	128, 889	109, 982		0	1.
.0			128, 889	109, 982		4	1.
	Grand Total: Decreases		322, 996	2, 243, 931		-	500.

Provider Provider CN: 15-0102 Period: From 01/01/2020 To 12/31/2020 Worksheet A-7 Dart I Date/Time Prepared: 7/29/2021 3:27 pm PART 1 - ANALYSIS OF CHANGES IN CAPITAL ASSET 1.00 Acquisitions 1.00 0 <t< th=""><th>Health Financial Systems</th><th>STARKE MEMORI</th><th>AL HOSPITAL</th><th></th><th>ln Li€</th><th>eu of Form CMS-2</th><th>2552-10</th></t<>	Health Financial Systems	STARKE MEMORI	AL HOSPITAL		ln Li€	eu of Form CMS-2	2552-10
Beginning Balances Purchases Donation Total Disposal s and Retirements 1.00 2.00 3.00 4.00 5.00 Land 142,789 0 0 0 0 2.00 Buildings and Fixtures 52,134 0 0 0 0 3.00 Buildings and Fixtures 1,760,186 0					Period: From 01/01/2020	Worksheet A-7 Part I Date/Time Pre	pared:
Balances Retirements 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 Land 1.00 2.00 3.00 4.00 5.00 1.00 Land Inprovements 52,134 0 0 0 0 2.00 3.00 Buil ding sand Fixtures 1.760,186 0 0 0 0 3.00 4.00 Buil ding Improvements 4,218,941 0 0 0 5.00 5.00 Fixed Equipment 1,097,772 0 0 0 5.00 6.00 Movable Equipment 9,390,151 0 0 0 8.00 9.00 Reconciling Items 0				Acqui si ti ons			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES Land 142,789 0 0 0 0 2.00 2.00 Buildings and Fixtures 122,789 0 0 0 0 2.00 3.00 Buildings and Fixtures 1,760,186 0 0 0 0 3.00 4.00 Building improvements 4,218,941 0 0 0 0 3.00 5.00 Fixed Equipment 9,390,151 0		Begi nni ng	Purchases	Donation	Total	Disposals and	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 142,789 0 0 0 0 1.00 2.00 Land Improvements 52,134 0 0 0 0 2.00 3.00 Buildings and Fixtures 1,760,186 0 0 0 0 3.00 4.00 Building Improvements 4,218,941 0 0 0 0 0 4.00 5.00 Fixed Equipment 1,097,772 0		Bal ances				Retirements	
1.00 Land 142,789 0 0 0 0 0 0 0 0 2.00 2.00 Land Improvements 52,134 0 0 0 0 0 2.00 3.00 Buil dings and Fixtures 1,760,186 0 0 0 0 0 0 3.00 4.00 Buil ding Improvements 4,218,941 0 0 0 0 4.00 5.00 Fixed Equipment 1,097,772 0 0 0 6.00 0 6.00 0 6.00 0 0 0 6.00 0 <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td>		1.00	2.00	3.00	4.00	5.00	
2.00 Land Improvements 52,134 0 0 0 0 2.00 3.00 Buildings and Fixtures 1,760,186 0 0 0 3.00 4.00 Building Improvements 4,218,941 0 <	PART I - ANALYSIS OF CHANGES I	N CAPITAL ASSET BALANCES		_			
3.00 Buildings and Fixtures 1,760,186 0 0 0 3.00 4.00 Building Improvements 4,218,941 0 0 0 0 4.00 5.00 Fixed Equipment 1,097,772 0 0 0 0 6.00 6.00 Movable Equipment 9,390,151 0 0 0 6.00 7.00 HIT designated Assets 0 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 16,661,973 0 0 0 8.00 9.00 Reconciling Items 0 0 0 0 0 9.00 9.00 Total (line 8 minus line 9) 16,661,973 0 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00	1.00 Land	142, 789	0	(0 0	0	1.00
4.00 Building Improvements 4,218,941 0 0 0 0 4.00 5.00 Fixed Equipment 1,097,772 0 0 0 0 5.00 6.00 Movable Equipment 9,390,151 0 0 0 0 0 6.00 7.00 HIT designated Assets 0	2.00 Land Improvements	52, 134	0	(0 0	0	2.00
5.00 Fixed Equipment 1,097,772 0 0 0 0 5.00 6.00 Movable Equipment 9,390,151 0 0 0 0 6.00 7.00 HIT designated Assets 0	3.00 Buildings and Fixtures	1, 760, 186	0	(0 0	0	3.00
6.00 Movable Equipment 9, 390, 151 0 <	4.00 Building Improvements	4, 218, 941	0	(0 0	0	4.00
7.00 HIT designated Assets 0 </td <td>5.00 Fixed Equipment</td> <td>1, 097, 772</td> <td>0</td> <td> (</td> <td>0 0</td> <td>0</td> <td>5.00</td>	5.00 Fixed Equipment	1, 097, 772	0	(0 0	0	5.00
8.00 Subtotal (sum of lines 1-7) 16,661,973 0 <td>6.00 Movable Equipment</td> <td>9, 390, 151</td> <td>0</td> <td> (</td> <td>0 0</td> <td>0</td> <td>6.00</td>	6.00 Movable Equipment	9, 390, 151	0	(0 0	0	6.00
9.00 Reconciling Items 0	7.00 HIT designated Assets	0	0	(0 0	0	7.00
10.00 Total (line 8 minus line 9) 16,661,973 0 0 0 0 0 10.00 Image: Image	8.00 Subtotal (sum of lines 1-7)	16, 661, 973	0	(0 0	0	8.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES Fully Depreciated Assets 6.00 7.00 1.00 1.00 1.00 2.00 Land 142,789 0 1.00 2.00 Land Improvements 52,134 0 2.00 3.00 Buildings and Fixtures 1,760,186 0 3.00 4.00 50.00 Fixed Equipment 9,300,151 0 4.00 5.00 6.00 7.00 5.00 6.00 7.00 4.00 5.00 6.00 7.00 4.00 5.00 6.00 7.00 4.00 5.00 6.00 7.00 4.00 5.00 6.00 7.00 4.00 5.00 6.00 7.00 9.00 8.00 9.00 7.72 0 6.00 7.00 5.00 6.00 7.00 7.72 0 6.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 <	9.00 Reconciling Items	0	0 0		0 0	0	9.00
PART I - ANALYSI S OF CHANGES IN CAPITAL ASSET Depreciated Assets Depreciated Assets <thdepreciated Assets Depreciated Asse</thdepreciated 	10.00 Total (line 8 minus line 9)	16, 661, 973	0	(o o	0	10.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 6.00 7.00 1.00 Land 142,789 0 1.00 2.00 Land Improvements 52,134 0 2.00 3.00 Buildings and Fixtures 1,760,186 0 3.00 4.00 Building Improvements 4,218,941 0 4.00 5.00 Fixed Equipment 9,390,151 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 16,661,973 0 8.00 9.00 Reconciling Items 0 0 9.00		Ending Balance	Fully				
Barry I ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 142,789 0 1.00 2.00 Land Improvements 52,134 0 2.00 3.00 Buildings and Fixtures 1,760,186 0 3.00 4.00 Building Improvements 4,218,941 0 4.00 5.00 Fixed Equipment 9,390,151 0 6.00 0 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 16,661,973 0 8.00 9.00 Reconciling Items 0 0 9.00		5	Depreciated				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 142,789 0 1.00 2.00 Land Improvements 52,134 0 2.00 3.00 Buildings and Fixtures 1,760,186 0 3.00 4.00 Building Improvements 4,218,941 0 4.00 5.00 Fixed Equipment 9,390,151 0 5.00 6.00 Movable Equipment 9,390,151 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 16,661,973 0 8.00 9.00 Reconciling Items 0 0 9.00			Assets				
1.00 Land 142,789 0 1.00 2.00 Land Improvements 52,134 0 2.00 3.00 Buildings and Fixtures 1,760,186 0 3.00 4.00 Building Improvements 4,218,941 0 4.00 5.00 Fixed Equipment 1,097,772 0 5.00 6.00 Movable Equipment 9,390,151 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 16,661,973 0 8.00 9.00 Reconciling Items 0 0 9.00		6.00	7.00				
2.00 Land Improvements 52,134 0 2.00 3.00 Buildings and Fixtures 1,760,186 0 3.00 4.00 Building Improvements 4,218,941 0 4.00 5.00 Fixed Equipment 1,097,772 0 5.00 6.00 Movable Equipment 9,390,151 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 16,661,973 0 8.00 9.00 Reconciling Items 0 0 9.00	PART I - ANALYSIS OF CHANGES I	N CAPITAL ASSET BALANCES					
3.00 Buildings and Fixtures 1,760,186 0 3.00 4.00 Building Improvements 4,218,941 0 4.00 5.00 Fixed Equipment 1,097,772 0 5.00 6.00 Movable Equipment 9,390,151 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 16,661,973 0 8.00 9.00 Reconciling Items 0 0 9.00	1.00 Land	142, 789	0				1.00
4.00 Building Improvements 4,218,941 0 4.00 5.00 Fixed Equipment 1,097,772 0 5.00 6.00 Movable Equipment 9,390,151 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 16,661,973 0 8.00 9.00 Reconciling Items 0 0 9.00	2.00 Land Improvements	52, 134	0				2.00
5.00 Fixed Equipment 1,097,772 0 5.00 6.00 Movable Equipment 9,390,151 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 16,661,973 0 8.00 9.00 Reconciling Items 0 0 9.00	3.00 Buildings and Fixtures	1, 760, 186	0				3.00
6.00 Movable Equipment 9, 390, 151 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 16, 661, 973 0 8.00 9.00 Reconciling Items 0 0 9.00	4.00 Building Improvements	4, 218, 941	0				4.00
7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 16,661,973 0 8.00 8.00 9.00	5.00 Fixed Equipment	1, 097, 772	0				5.00
8.00 Subtotal (sum of lines 1-7) 16,661,973 0 8.00 9.00	6.00 Movable Equipment	9, 390, 151	0				6.00
9.00 Reconciling Items 0 0 9.00	7.00 HIT designated Assets	0	0 0				7.00
9.00 Reconciling Items 0 0 9.00	8.00 Subtotal (sum of lines 1-7)	16, 661, 973	8 0				8.00
10.00 Total (line 8 minus line 9) 16,661,973 0 10.00			0				9.00
	10.00 Total (line 8 minus line 9)	16, 661, 973	8 0				10.00

Heal th	Financial Systems	STARKE MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0102	Period:	Worksheet A-7	
					From 01/01/2020 To 12/31/2020		narod
					10 12/31/2020	7/29/2021 3:2	7 pm
			SL	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		9.00	10.00	11.00	instructions) 12.00	instructions) 13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	-40, 575			0 0	0	1.00
2.00	CAP REL COSTS-BEDG & TTXT	576, 397	0			0	2.00
3.00	Total (sum of lines 1-2)	535, 822	0		0 0	0	3.00
		SUMMARY OF					
	Cost Center Description	Other :	Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	45.00	-			
	DADT LL DECONCLULATION OF ANOUNTS FROM WORL	14.00	15.00				
1 00	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEEL A, CULUM					1 00
1.00 2.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	0	-40, 575 576, 397				1.00
2.00	Total (sum of lines 1-2)	0					2.00 3.00
3.00	Total (Sull of Titles 1-2)	U U	535, 822				J 3.00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	1	Period: From 01/01/2020 To 12/31/2020	Worksheet A-7 Part III Date/Time Prep 7/29/2021 3:27	
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPI TAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 CAP REL COSTS-BLDG & FIXT	7, 271, 822				0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	9, 390, 151		.,		0	2.00
3.00 Total (sum of lines 1-2)	16, 661, 973		16, 661, 97			3.00
	ALLOCA	TION OF OTHER (CAPITAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				0 007 ((4		4 00
	0	, s		0 227, 661	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	0		0 596, 751 0 824, 412	0	2.00
3.00 Total (sum of Trifes T-2)	0		JMMARY OF CAPI		0	3.00
		30	JWWART OF CAPT	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI		44 770	117.05	(200 747	1 00
1.00 CAP REL COSTS-BLDG & FLXT 2.00 CAP REL COSTS-MVBLE EQUIP	0			6 0 0 0	300, 747 599, 318	1.00 2.00
3.00 Total (sum of lines 1-2)	0				599, 318 900, 065	2.00
3.00 ± 10 car (sum of times $1-2$)	0	1 -42, 203	1 117,00		300,005	5.00

DJUST	Financial Systems MENTS TO EXPENSES			L HOSPITAL Provider CCN: 15-0102	Peri od:	worksheet A-8	
					From 01/01/2020 To 12/31/2020		pared
			1	Expense Classification (To/From Which the Amount i			
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
. 00	Investment income - CAP REL			CAP REL COSTS-BLDG & FIXT	1.00		1. C
. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		oc	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. (
. 00	Investment income - other		О		0.00	0	3. (
00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. (
00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.
00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.
. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter	В	-11, 706 A	DMI NI STRATI VE & GENERAL	5.00	0	7.
00	21) Tel evi si on and radi o servi ce	В	-7230	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.
00	(chapter 21) Parking lot (chapter 21) Provider-based physician	A-8-2	0 -2, 593, 388		0.00	0	9. 10.
	adjustment Sale of scrap, waste, etc.	В		ADI OLOGY-DI AGNOSTI C	54.00		
2. 00	(chapter 23)	A-8-1	4, 159, 660		01.00	0	
	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.
4.00	Cafeteria-employees and guests Rental of guarters to employee		-71, 308 C	CAFETERI A	11.00 0.00	0	14. 15.
5. 00	and others Sale of medical and surgical supplies to other than	В		MPL. DEV. CHARGED TO PATIENTS	72.00	0	16.
7.00	patients Sale of drugs to other than patients	В	-7, 411 D	RUGS CHARGED TO PATIENTS	73.00	0	17.
8. 00	1.	В	-1, 223N	IEDI CAL RECORDS & LI BRARY	16.00	0	18.
. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.
	Vending machines		0		0.00		
. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.
2. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.
3. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	OR	RESPIRATORY THERAPY	65.00		23.
4. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	OF	PHYSICAL THERAPY	66.00		24.
5.00	Utilization review - physicians' compensation		ou	ITILIZATION REVIEW-SNF	114.00		25.
. 00	(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT	А	148, 218 C	CAP REL COSTS-BLDG & FIXT	1.00	9	26.
. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP	А		CAP REL COSTS-MVBLE EQUIP	2.00	9	27.
	Non-physician Anesthetist Physicians'assistant		0	** Cost Center Deleted **	* 19.00 0.00		28. 29.
	Adjustment for occupational therapy costs in excess of	A-8-3	oc	OCCUPATI ONAL THERAPY	67.00		29. 30.
. 99	limitation (chapter 14) Hospice (non-distinct) (see		٩O	DULTS & PEDIATRICS	30.00		30.
. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	os	SPEECH PATHOLOGY	68.00		31.
2. 00	Limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.
	Depreciation and Interest TRAINING REVENUE	В		IURSI NG ADMI NI STRATI ON	13.00		33.

Heal th	Financial Systems		STARKE MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
ADJUS	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 01/01/2020 To 12/31/2020	Date/Time Pre 7/29/2021 3:2	pared: 7 pm
				Expense Classification or	n Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	RENTAL INCOME	В		CAP REL COSTS-BLDG & FIXT	1.00		
33.03	GRANT INCOME	В		ADMINISTRATIVE & GENERAL	5.00		33.03
33.04	OTHER MI SCELLANEOUS REVENUE	В		ADMI NI STRATI VE & GENERAL	5.00		33.04
33.05	TELEPHONE DEPRECIATION EXPENSE		-243	CAP REL COSTS-MVBLE EQUIP	2.00		33.05
33.06	TELEVI SI ON EXPENSE	В	-11, 406	ADMI NI STRATI VE & GENERAL	5.00	0	33.06
33.07	OTHER ADJUSTMENTS (SPECIFY)	A	0		0.00	0	33.07
	(3)						
33.08	MARKETING DEPARTMENT	В	-69, 679	ADMI NI STRATI VE & GENERAL	5.00	0	33.08
33.09	CHARI TBABLE CONTRI BUTI ONS	A	0	ADMI NI STRATI VE & GENERAL	5.00	0	33.09
33.10	OTHER ADJUSTMENTS (SPECIFY)	В	0		0.00	0	33. 10
	(3)						
33. 11	ALLOCATED RENT EXPENSE	В	36, 144	PHYSICIANS' PRIVATE OFFICES	192.00	0	33. 11
33. 12	PHYSICIAN GUARANTEE	А	0	CLINIC	90.00	0	33. 12
33.13	MEALS & EVENTS	В	-92	ADMI NI STRATI VE & GENERAL	5.00		33.13
33.14	ASSOCIATION DUES	В		ADMI NI STRATI VE & GENERAL	5.00		33.14
50.00	TOTAL (sum of lines 1 thru 49)	-	1, 313, 583		5.00	Ū	50.00
00.00	(Transfer to Worksheet A,		., 0.0, 000				50.00
	column 6, line 200.)						

(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.

Heal th	Financial Systems	STARKE MEMOR	REAL HOSPETAL	In Lie	eu of Form CMS-2	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Peri od:	Worksheet A-8	-1
OFFI CE	COSTS			From 01/01/2020 To 12/31/2020		narod
				10 12/31/2020	7/29/2021 3:2	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
	1.00	0.00	2.00	1.00	5	
				4.00	5.00	
	A. COSTS INCURRED AND ADJUSTN HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAIMED	
1.00		CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	3,050	0	1.00
2.00		CAP REL COSTS-DEDG & TTXT	PASI Capital Costs - Moveabl			2.00
3.00		ADMINISTRATIVE & GENERAL	PASI Operating Costs	85, 758		3.00
4.00		ADMINISTRATIVE & GENERAL	Shared Service Center Alloca		119, 443	4.00
4.01		CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix			4.01
4.02		CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm			4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	Non-Capital Home Office Cost		0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	Malpractice Costs	10, 872	222, 238	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	Interest Expense	0	-4, 124, 145	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	Management Fees	0	351, 466	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	401K Fees	0	6, 756	4.07
4.08		ADMINISTRATIVE & GENERAL	Audit Fees	0	10, 636	4.08
4.09		ADMINISTRATIVE & GENERAL	Corporate Overhead Allocatic	0	216, 688	4.09
4.10		ADMINISTRATIVE & GENERAL	HIIM Allocation	0	78, 115	4.10
4.11		ADMINISTRATIVE & GENERAL	Contract Management	0	18, 000	4.11
4.12		ADMINISTRATIVE & GENERAL	PASI Lien Unit Collection Fe		262	4.12
5.00	TOTALS (sum of lines 1-4).			1, 150, 343	-3, 009, 317	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

* 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

1100 110	t been posted to norkaneet n;						
				Related Organization(s) and/	or Home Office	i i	
						í.	
						i i	
						i i	
						i i	
	Symbol (1)	Name	Percentage of	Name	Percentage of	i i	
			Ownership		Ownershi p	í.	
			· · · · ·			·	
	1.00	2.00	3.00	4.00	5.00	i i	
	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	В	0.00 COMMULNETY HEAL 100.00	6.00
7.00	В	0.00 PASI 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		100.00
	non-financial) specify:		

(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 organi zati on.

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 provi der.

Health Financial Systems	STARKE MEMORIAL HO)SPI TAL	In Lieu	of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM F OFFICE COSTS	RELATED ORGANIZATIONS AND HOME PI		Period: From 01/01/2020	Worksheet A-8-1
				Date/Time Prepared:

					7/29/2021 3:	27 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00	· · · · · ·			
			ENTS REQUIRED AS A RESULT OF TR	ANSACTIONS WITH RELATED C	ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO					_
1.00	3, 050					1.00
2.00	378					2.00
3.00	-5, 466					3.00
4.00	308, 083					4.00
4.01	19, 138					4.01
4.02	20, 619					4. 02
4.03	583, 002					4.03
4.04	-211, 366					4.04
4.05	4, 124, 145					4.05
4.06	-351, 466					4.06
4.07	-6, 756					4.07
4.08	-10, 636					4.08
4.09	-216, 688					4.09
4.10	-78, 115					4.10
4.11	-18,000					4.11
4.12	-262					4. 12
5.00	4, 159, 660					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.

Rel ated 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 ent under title VVIII

i ei iibui	Sement under title AVIII.							
6.00	HOSP COMPANY	6.00						
7.00	COLLECTI ONS	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								

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 organi zati on.

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 provi der.

Heal th	Financial Syste	ems	STARKE MEMOR	IAL HOSPITAL		In Li	eu of Form CMS-	2552-10
PROVIDER BASED PHYSICIAN ADJUSTMENT			Provider CCN: 15-0102		Period: Worksheet A-8-2			
)	
						To 12/31/2020	7/29/2021 3:2	<u>27 pm</u>
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS &	369, 316	369, 316		0 0	0	1.00
		PEDI ATRI CS						
2.00	53.00	AGGREGATE - ANESTHESI OLOGY	188, 333	188, 333		o l	0	2.00
3.00	60,00	AGGREGATE-LABORATORY	27,000	27,000		o l	0	3.00
4.00		AGGREGATE-CLI NI C	470, 771	470, 771			0	4.00
5.00		AGGREGATE - EMERGENCY	1, 537, 968	1, 537, 968			0	5.00
6.00	0.00		1,007,700	0			0	1
7.00	0.00		0	0			0	7.00
8.00	0.00		0	0			0	8.00
			-	0			0	
9.00	0.00		0	0		0 0		1 1.00
10.00	0.00		0	0		0 0	0	101.00
200.00			2, 593, 388	2, 593, 388		D	0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS &	0	0		0 0	0	1.00
		PEDI ATRI CS						
2.00	53.00	AGGREGATE-ANESTHESI OLOGY	0	0		0 0	0	2.00
3.00	60.00	AGGREGATE-LABORATORY	0	0		o l	0	3.00
4.00	90.00	AGGREGATE-CLI NI C	0	0		o l	0	4.00
5.00		AGGREGATE - EMERGENCY	0	0			0	5.00
6.00	0.00		0	0			0	
7.00	0.00		0	0			-	
8.00	0.00		0	0			-	8.00
9.00	0.00		0	0			0	
			0	0			0	
10.00	0.00		0				, o	
200.00			0	0		°	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	0.00	14	1/ 00	17.00	10.00	-	
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS &	0	0		369, 316		1.00
		PEDI ATRI CS						
2.00		AGGREGATE-ANESTHESI OLOGY	0	0		0 188, 333		2.00
3.00		AGGREGATE-LABORATORY	0	0		27,000	1	3.00
4.00		AGGREGATE-CLI NI C	0	0		0 470, 771		4.00
5.00	91.00	AGGREGATE-EMERGENCY	0	0		1, 537, 968		5.00
6.00	0.00		0	0		o o		6.00
7.00	0.00		0	0		0		7.00
8.00	0.00		0	0				8.00
9.00	0.00		0	0				9,00
9.00 10.00	0.00		0	0				9.00 10.00
	0.00		0	0				200.00
200.00	I	l	0	0	I	2, 593, 388	1	200.00

	Financial Systems	STARKE MEMORI			In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS				Period: From 01/01/2020	Worksheet B Part I	
					To 12/31/2020	Date/Time Pre	
			CAPI TAL RELATED COSTS			7/29/2021 3:2	
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A					
		<u>col.7)</u> 0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS	Ū	1.00	2.00	1.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	300, 747	300, 747				1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	599, 318 1, 006, 699	600	599, 318 1, 196			2.00 4.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL	3, 815, 651	20, 309	40, 47		4, 014, 538	•
7.00	00700 OPERATION OF PLANT	1, 694, 751	69, 536	138, 565		1, 902, 852	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	54, 537	0	(121, 026	•
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	367, 037 75, 771	7, 385 7, 806	14, 717 15, 555		423, 307 106, 686	
11.00	01100 CAFETERI A	167, 563	2, 128	4, 240		194, 216	•
13.00	01300 NURSI NG ADMI NI STRATI ON	215, 628	981	1, 955		255, 449	•
14.00	01400 CENTRAL SERVICES & SUPPLY	151, 447	4, 995	9, 955		177, 659	•
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	264, 374 139, 217	3, 414 2, 814	6, 804 5, 608		311, 953 156, 007	•
	01700 SOCIAL SERVICE	27, 576	0	(31, 614	•
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	000 007		55.34	100.010	4 014 004	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	992, 037 0	27, 960 0	55, 719		1, 214, 026 0	1
40.00	04000 SUBPROVI DER – I PF	0	0	(-	0	
41.00	04100 SUBPROVI DER – I RF	0	0	(0	
43.00		0	0	(0 0	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	533, 333	30, 397	60, 574	1 57, 896	682, 200	50.00
51.00	05100 RECOVERY ROOM	0	0	(0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(-	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	825 588, 254	0 12, 906	(25, 718	- -	825 697, 909	•
54.00 54.01	05401 ULTRASOUND	80, 999	12, 900	23, 710		92, 052	•
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(0	1
56.00	05600 RADI OI SOTOPE	33, 796	0	(.,	35, 372	•
57.00 58.00	05700 CT SCAN 05800 MRI	73, 795 18, 793	1, 725 4, 550	3, 438 9, 067		86, 789 35, 067	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	4, 330	, 00	0 0	0	1
60.00	06000 LABORATORY	900, 039	7, 051	14, 051	1 85, 269	1, 006, 410	•
62.00 64.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06400 INTRAVENOUS THERAPY	0	0			0	
65.00	06500 RESPIRATORY THERAPY	338,971	3, 055	6, 088	48,974	397, 088	•
66.00	06600 PHYSI CAL THERAPY	374,066	7, 712	15, 369		447, 532	
	06700 OCCUPATI ONAL THERAPY	0	0	(0 0		67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 120, 234	0 1, 581	3, 15	0 1 17,057	0 142, 023	
	07000 ELECTROENCEPHALOGRAPHY	120, 234	0	3, 13	0 0	0	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9, 519	0	(0 0	9, 519	
	07200 I MPL. DEV. CHARGED TO PATIENTS	11, 152	0	(0	11, 152	•
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	366, 941 0	0			366, 941 0	1
	07500 ASC (NON-DI STI NCT PART)	0	0	(0 0	0	
	03030 ANGI OCARDI OGRAPHY	0	0	(0 0	0	76.00
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	(0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	•
90.00	09000 CLI NI C	0	0	(0 0	0	
	09100 EMERGENCY	1, 146, 628	14, 695	29, 284	151, 939		
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS					0	92.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	(0 0	0	94.00
	09500 AMBULANCE SERVICES	0	0	(0 0	0	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD	0	0			0	
	09900 CMHC	0	0	(0	
99.10	09910 CORF	0	0	(o o	0	99.10
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	(0		100.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	(0 0	0	101.00
105.00	10500 KIDNEY ACQUISITION	0	0	(0 0	0	105.00
106.00	10600 HEART ACQUI SI TI ON	0	0	(0 0	0	106.00
	10700 LIVER ACQUISITION 10800 LUNG ACQUISITION	0	0				107.00 108.00
	10900 PANCREAS ACQUISITION	0	0				108.00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	<u> </u>	0	· · · · ·			

Health Financial Systems	STARKE MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2020 Fo 12/31/2020	Worksheet B Part I Date/Time Pre 7/29/2021 3:2	
		CAPI TAL REL	_ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
110. 00 11000 I NTESTI NAL ACQUI SI TI ON 111. 00 11100 I SLET ACQUI SI TI ON 113. 00 11300 I NTEREST EXPENSE	0	0 0		0 0 0		110.00 111.00 113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		115.00
116.00 11600 HOSPI CE	0	0	(0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	14, 469, 698	231, 600	461, 52	5 1, 008, 495	14, 262, 758	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		1, 790	3, 56	7 0	E 257	190.00
190:0019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 790	3, 30			190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
193. 0019300 NONPALD WORKERS	0	0		0 0		193.00
194. 00 07950 SPECIALTY CLINICS / MOB	0	67,357	134, 22	6 0	201, 583	
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)	14, 469, 698	300, 747	599, 31	1, 008, 495	14, 469, 698	202.00

Heal th	Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2020	Worksheet B Part I	
				Т		Date/Time Pre 7/29/2021 3:2	pared: 7 pm
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	-		ſ			
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	4, 014, 538					5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	730, 648 46, 471	2, 633, 500				7.00 8.00
8.00 9.00	00900 HOUSEKEEPING	46, 471	0 92, 483		678, 330		9.00
10.00	01000 DI ETARY	40, 965	97, 749		26, 094	273, 455	•
11.00	01100 CAFETERIA	74, 574	26, 642		7, 112	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	98, 087	12, 286		3, 280	0	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	68, 217 119, 783	62, 556 42, 754		16, 699 11, 413	0	14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	59, 903	35, 238		9, 407	0	16.00
17.00	01700 SOCIAL SERVICE	12, 139	0	0	0	0	17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	466, 158	350, 131	38, 549	93, 468	273, 455	30.00
30.00	03100 I NTENSI VE CARE UNI T	400, 138	350, 131		93, 400	273, 455	31.00
40.00	04000 SUBPROVI DER – I PF	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
50.00	ANCI LLARY SERVI CE COST CENTERS	261, 949	380, 644	17, 686	101, 614	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	317 267, 981	0 161, 609	0 27, 818	0 43, 142	0	53.00 54.00
54.00 54.01	05400 RADIOLOGI - DI AGNOSTI C	35, 346	0		43, 142	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00	05600 RADI OI SOTOPE	13, 582	0	0	0	0	56.00
57.00 58.00	05700 CT SCAN 05800 MRI	33, 325 13, 465	21, 602 56, 975		5, 767 15, 210	0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	13, 403	0	0	15, 210	0	59.00
60.00	06000 LABORATORY	386, 438	88, 298	0	23, 571	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	152 472	0	0	0	0	64.00
65.00 66.00	06600 PHYSI CAL THERAPY	152, 473 171, 842	38, 253 96, 579			0	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0,020	20, 702	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00		54, 534	19, 802	0	5, 286	0	69.00
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 655			0	0	70.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	4, 282	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	140, 897	0	0	0	0	•
74.00 75.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	74.00 75.00
76.00	03030 ANGI OCARDI OGRAPHY	0			0	0	
10100	OUTPATIENT SERVICE COST CENTERS					Ŭ	/ 01 00
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00 90.00
90.00 91.00	09100 EMERGENCY	515, 507	184, 021	73, 648	49, 125	0	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				, .20		92.00
04.05	OTHER REIMBURSABLE COST CENTERS			-			04.00
94.00 95.00	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0	0	0	0	0	94.00 95.00
95.00 96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	95.00 96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99.00	09900 CMHC	0	0	0	0	0	99.00
	09910 CORF 10000 I&R SERVICES-NOT APPRVD PRGM	0			0	0	99.10 100.00
	10100 HOME HEALTH AGENCY	0	0	0	0		101.00
	SPECIAL PURPOSE COST CENTERS			-	-		
	10500 KI DNEY ACQUI SI TI ON	0	0	0	0		105.00
	10600 HEART ACQUI SI TI ON 10700 LI VER ACQUI SI TI ON	0			0		106.00 107.00
	10800 LUNG ACQUISITION	0	0	0	0		107.00
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
	11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
	11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE	0	0	0	0	0	111.00 113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115.00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period:	Worksheet B	
				From 01/01/2020	Part I	
				To 12/31/2020	Date/Time Pre	
					7/29/2021 3:2	/pm
Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5.00	7.00	8.00	9.00	10.00	
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 935, 078	1, 767, 622	167, 49	7 447, 182	273, 455	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,057	22, 412		5, 983	0	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	0	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194.0007950 SPECIALTY CLINICS / MOB	77, 403	843, 466		0 225, 165	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	4, 014, 538	2, 633, 500	167, 49	7 678, 330	273, 455	202.00

Dist ALIDATION - GREAN SERVICE COSTS Provide CD: 15.000 Period	Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
Line 1/2/31/2000 Line Strate (inc) (inc) (inc) Cost Center Description Auxin (ISTRAT) (Inc) Central, Service (Inc) Prevence Prevence 1 00 00000 (Inc) 13.00 14.00 15.00 16.00 1 00 0000 (Inc) 15.00 16.00 10.00 10.00 1 00 0000 (Inc) 15.00 14.00 10.00 10.00 1 00 0000 (Inc) 14.00 10.00	COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC				
Cost Center Description CATTERIA (MUNIN STRATION 100 NUERS INF. (SUBJOR 25, 200, CS 2, 4 (SUBJOR 25, 200, CS 2, 4						Date/Time Pre	
THEMAL SERVICE COST CHITLES 11 00 13 00 14 00 19 00 10 00 STREAL SERVICE COST CHITLES 1 00 1000 10000	Cost Center Description	CAFETERI A	NURSI NG		PHARMACY	MEDI CAL	
III.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 2.00 00200 CAP FEL COST F-MPME LEDUTY 1.00 4.00			ADMI NI STRATI ON				
100 DOTOD CAP FILL COSTS-RULE & FIXI 2.00 200 DOTOD CAP FILL COSTS-RULE & FIXI 2.00 4 DODOD CAP FILL COSTS-RULE & FIXI 2.00 4 DODOD CAP FILL COSTS-RULE & FIXI 2.00 4 DODOD CAP FILL COSTS-RULE & FIXI 2.00 0 DODOD CAP FILL COSTS-RULE & FIXI 3.00 10 DOTOD CAP FILL COSTS-RULE & FIXI 5.00 10 DOTOD CAP FILL COSTS CAP FILL & FIXI 5.00 10 DOTOD CAP FILL COSTS CAP FILL & FIXI 5.00 10 DOTOD CAP FILL COSTS CAP FILL & FIXI 5.00 10 DOTOD CAP FILL COSTS CAP FILL & FIXI 5.00 10 DOTOD CAP FILL COSTS CAP FILL & FIXI 5.00 10 DOTOD CAP FILL COSTS CAP FILL & FIXI 5.00 10 DOTOD CAP FILL COSTS CAP FILL & FIXI 5.00 10 DOTOD CAP FILL COSTS CAP FIXI 5.00 10 <td></td> <td>11.00</td> <td>13.00</td> <td></td> <td>15.00</td> <td></td> <td></td>		11.00	13.00		15.00		
2.00 00000 CAP HEL COSIS-MUEL EURIP 4.00 4.00 00000 CAPTENT IN THE A TENNU 4.00 5.00 00000 CAPTENT IN THE A TENNU 5.00 6.00 00000 CAPTENT IN THE A TENNU 5.00 6.00 00000 CAPTENT IN THE A TENNU 7.071 370, 173 6.00 00000 CAPTENT IN THE A TENNU 7.071 370, 173 1.00 6.00 00000 CAPTENT IN THE A TENNU 7.071 370, 173 1.00 6.00 010000 CAPTENT IN THE A TENNU 7.071 370, 173 1.00 6.00 010000 CAPTENT IN THE A TENNU 7.071 370, 173 1.00 6.00 010000 CAPTENT IN THE A TENNU 7.071 370, 173 1.00 6.00 010000 CAPTENT IN THE A TENNU 7.071 370, 173 1.00 6.00 010000 CAPTENT IN THE A TENNU 7.071 370, 174 1.00 1.00 7.00 170000 CAPTENT IN THE A TENNU 1.00 1.00 1.00 1.00 7.00 10000 CAPTENT IN THE A TENNU 1.17,74 1.00 1.00 1.0			1 1				1.00
4.00 000000 00000 00000 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
7.00 00700 DEPENTION PERMIT 7.00 7.00 0.00 7.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
B. DD DDDDD LMMDRY A: LINEN SLEVICE 8.00 D. DDDD LINEN STEPT MA 307.544 7.071 D. DDDD LINEN STEPT MA 307.544 7.071 J. DDD DIAD DITTAR 10.00 11.00 J. DDD DIAD DITTAR 331.002 331.002 J. DDD DIAD DIAD DIAD J. DDD J. DDD J. DDD DIAD DIAD DIAD J. DDD J. DDD <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
9.00 0000000000000000000000000000000000							
11.00 01100 CAFETERIA 302, 514 11.00 14.00 01400 CHYNRAL SERVICES A SUPPLY 5, 961 331, 022 14 14.00 01400 CHYNRAL SERVICE A SUPPLY 5, 961 331, 022 15 15.00 01700 SCIAL SERVICE 1, 440 0 0 0 17.00 17.00 01700 SCIAL SERVICE 4, 194 0 0 0 0 0 0 17.00 17.00 SCIAL SERVICE 44, 191 14.8, 974 2.6, 899 0 15, 467 3.0, 00 17.00 SCIAL SERVICE 44, 191 14.8, 974 2.6, 899 0 15, 467 3.0, 00 10.00 SCIAL SERVICE SCI ENTERS 0<							
13.00 01 300 NURSIN KO ADM IN STRATION 7,071 376,172 331,077 14.00 14.00 01 500 FMARMACY 0.5 5,960 304 496,392 15.00 15.00 01 500 FMARMACY 0.5 304 238 0 266,000 15.00 16.00 15.00 15.00 0 0 0 0 16.00 16.00 15.00 15.00 0 0 0 0 16.00 10.00 05100 INTERS EVENCE COST CENTERS 1.044,197 148,976 26.089 0		200 544					
14.00 014.00 CENTRAL SERVICES & SUPPLY 5.60 0 33.1 002 495.372 2 16.00 014.00 LECORDS & LIBARY 5.30 0							
16. 00 0 frac0 UED CAL BECOMDS A LIBRAYY 5. 30 0 238 0 266, 09 16. 00 10.00 0 color AL SERVICE COST CENTERS - <td< td=""><td></td><td></td><td></td><td>331, 092</td><td></td><td></td><td></td></td<>				331, 092			
17.00 01700 SOCIAL SERVICE 1.040 4.284 0 0 0 17.00 IMPATELER MUTHE SERVICE COST CENTES 44.191 148.978 26.889 0 15.40 30.00 10.00 01300 JABL IS & PERANCE COST CENTES 0			1				
Infant ENT ROUT NE SERVICE COST CENTERS Image: Cost of Control of Cost ost of Cost ost of Cost of Cost of Cost of Cost of Cost of Cost							•
11. 00 03100 INTERSIVE CARE UNIT 0		1,040	<u>ч, 204</u>	0	0	0	17.00
40. 00 04000 SUBPROVIDER - IPF 0<					-	-	
11.00 01100 SUBPROVIDER - 1 RF 0		-		-	-		
ANCILLARY SERVICE COST CENTRES Image: Cost Centres Image: Cost Centres 0.00 05000 (PERATINE ROW 17.74 o 51.00 0 0 0 50.00 51.00 05100 (RECOVERY ROW 0 0 0 0 0 55.00 52.00 05200 (RECEVERY ROW 0 0 0 0 0 0 55.00 53.00 05300 (AMESTHESI OLCY 0 <td></td> <td></td> <td>Ŭ</td> <td>0</td> <td>-</td> <td></td> <td></td>			Ŭ	0	-		
50. 00 65000 (DEPEATING ROOM 17, 744 51, 054 78, 815 0 30, 186 50. 00 510 51, 054 78, 815 0 30, 186 50. 00 510 51, 00 510 51, 00 510 51, 00 510 51, 00 510 51, 00 52, 00 52, 00 52, 00 51, 00 52, 00 63, 00 52, 00 64, 00 64, 01 52, 00 64, 01 64, 01 64, 01 64, 01 55, 00 66, 00		C	0 0	0	0	0	43.00
51.00 05100 RECOVERY ROM 0		17 746	51 054	78 815	0	30 186	50.00
53.00 OS300 ANESTHESI OLGOY 0 203 0 6.595 53.00 54.00 OS400 ULTRASOUND 3,119 0 1,993 0 6,977 54.01 55.00 OS500 RADIOLOCY-THERAPEUTIC 0 0 0 0 55.00 55.00 OS500 RADIOLOCY-THERAPEUTIC 0 0 0 46.977 54.01 55.00 OS500 CTSCAH 2.322 203 10.569 0 34.653 57.00 59.00 OS600 CARDIA CATHETERIZATION 0 </td <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td>					-		
54.00 05400 RADILOGY-ID AGNOSTIC 22,044 1,549 18,360 0 14.004 54.00 55.00 05500 RADILOGY-THERAPEUTIC 0 <t< td=""><td></td><td></td><td></td><td>-</td><td>-</td><td></td><td></td></t<>				-	-		
54 01 0 55-00 0 0 <t< td=""><td></td><td></td><td>U U</td><td></td><td>°,</td><td></td><td></td></t<>			U U		°,		
65 00 OS500 RADIO IS SOTOPE 381 0 4,830 0 1,877 65,00 57 00 OS700 CT SCAN 2,322 203 10,569 0 7,966 58,00 7,966 58,00 7,966 58,00 7,966 58,00 7,966 58,00 7,966 58,00 7,966 58,00 7,966 58,00 7,966 58,00 7,960 59,00 59,00 59,00 59,00 59,00 59,00 59,00 59,00 59,00 59,00 59,00 59,00 59,00 60,00 51,386 60,00 60,00 60,00 60,00 60,00 61,00 60,00					°,		1
77.00 00 DS700 CT SCAN 2, 222 203 10.569 00 34, 653 57.00 58.00 DS900 CARDIA C CATHETERIZATION 0 0 0 58.00 59.00 DS900 CARDIA C CATHETERIZATION 0 0 0 0 59.00 60.00 GOCOL LABORATORY 32.268 2,607 124,487 0 51.386 60.00 64.00 O400 0 0 0 0 0 62.00 65.00 D6500 IFREAPY 19.132 921 0 8.817 66.00 66.00 O6700 OCUPATIONAL THERAPY 19.132 0 0 0 67.00 0 0 67.00 0 <td>55. 00 05500 RADI OLOGY-THERAPEUTI C</td> <td></td> <td>1</td> <td></td> <td>0</td> <td>0</td> <td>55.00</td>	55. 00 05500 RADI OLOGY-THERAPEUTI C		1		0	0	55.00
B8.00 OSB00 MRI 728 0 379 0 7,966 58.00 59.00 DOSDO CARDIAC CATHETERIZATION 0			1		-		
99.00 OS900 (ARDIAC CATHETER ZATION 0 0 0 0 0 59.00 60.00 06000 (LABORATORY 32, 268 2, 607 124, 487 0 51, 386 60.00 70.00<					°,		1
62:00 00 00 0 </td <td>59. 00 05900 CARDI AC CATHETERI ZATI ON</td> <td></td> <td>1</td> <td></td> <td>0</td> <td></td> <td>•</td>	59. 00 05900 CARDI AC CATHETERI ZATI ON		1		0		•
64.00 0 <td></td> <td></td> <td></td> <td></td> <td>0</td> <td></td> <td>•</td>					0		•
65.00 06500 RESPIRATORY THERAPY 16,047 0 2,832 0 8,817 66.00 66.00 06000 PY31CAL THERAPY 19,132 0 0 0 0 66.00 67.00 66.00 67.00 68.00 0 0 0 0 0 66.00 66.00 70.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 72.00 72.00 72.00 0 0 0 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 0		-	-	-	0	-	•
67.00 OCOUPATIONAL THERAPY O <td>65. 00 06500 RESPI RATORY THERAPY</td> <td></td> <td></td> <td>2, 832</td> <td>0</td> <td></td> <td>65.00</td>	65. 00 06500 RESPI RATORY THERAPY			2, 832	0		65.00
68.00 06800 SPECH PATHOLOGY 0 0 0 68.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 70.00 7					0		
69:00 06:00 ELECTROCARD LOGY 5,546 1,041 933 0 10.955 69:00 70:00 07000 ELECTROCREPHALOGRAPHY 0 0 0 0 70:00 71:00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 66:00 72:00 73:00 07300 RUGS CHARGED TO PATIENTS 0 0 0 495;392 28:166 73:00 74:00 07400 RENAL DI ALYSIS 0 0 0 0 74:00 75:00 07500 ASC (MON-DI STI KCT PART) 0 0 0 0 0 75:00 00 03303 ANGI OCARDI OGRAPHY 0 0 0 0 0 0 76:00 00 03000 REDBERALLY OLALIFIC ENTERS 0 0 0 0 0 98:00 90:00 09000 CLI NI C 0 0 0 0 0 0 99:00 91:00 09200 CLI NI C 0		-	-		0		
71.00 07100 MEDI CAL. SUPPLIES CHARGED TO PATIENT 0 0 0 1,089 71.00 72.00 07300 DPL. DEV. CHARGED TO PATIENTS 0 0 0 620 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 495, 392 28, 106 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 0 74.00 75.00 76.00 76.00 0 0 0 76.00 76.00 76.00 76.00 88.00 88.00 88.00 88.00 89.00 90.	69. 00 06900 ELECTROCARDI OLOGY	5, 546	1, 041	-	0		
72.00 07200 MPL_DEV. CHARGED TO PATIENTS 0 0 0 620 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 495,392 28,106 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 </td <td></td> <td>C</td> <td>0</td> <td></td> <td>0</td> <td></td> <td></td>		C	0		0		
73.00 OT300 DRUGS CHARGED TO PATIENTS 0 0 495,392 28,106 73.00 74.00 OT400 RENAL DIALYSIS 0				0	0		
75.00 07500 ASC (NON-DI STINCT PART) 0 <th< td=""><td></td><td>C</td><td>0</td><td>0</td><td>495, 392</td><td></td><td></td></th<>		C	0	0	495, 392		
76.00 03030 ANGLOCARDI OGRAPHY 0 0 0 0 0 0 76.00 OUTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 88.00 08800 RRAL HEALTH CLINIC 0		C	0	0	0		•
OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 99.00 08800 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 90.00 09000 CLINIC 0	· · · · ·		0	0	0		
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0	OUTPATIENT SERVICE COST CENTERS	-	-	-	-1		
90.00 09000 CLINIC 0		C	0	0	0	0	
91.00 09100 EMERGENCY 42,111 166,457 59,330 0 45,017 91.00 92.00 07400 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 92.00 94.00 92.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 95.00 94.00 94.00 95.00 94.00 94.00 95.00 94.00 95.00 94.00 97.00 97.00 97.00 99.00 94.00 94.00 97.00 99.00 99.00 94.00 0 0 0 100.00			0	0	0	0	•
OTHER REI MBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 94.00 95.00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 95.00 96.00 96.00 0 0 0 0 0 0 0 0 0 0 0 0 97.00 0	91. 00 09100 EMERGENCY	42, 111	166, 457	59, 330	0	45, 017	
94.00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 94.00 95.00 09500 AMBULANCE SERVI CES 0 0 0 0 0 95.00 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 96.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97.00 99.00 OMPCO CMHC 0 0 0 0 97.00 99.00 99.10 09910 CORF 0 0 0 0 99.00 0 99.00 0 99.00 0 0 0 0 99.00 0 0 0 0 99.00 0 0 0 0 0 100.00 0							92.00
95.00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97.00 99.00 09900 CMHC 0 0 0 0 97.00 99.10 09910 CORF 0 0 0 0 99.10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 101.00 10500 KIDNEY ACQUISITION 0 0 0 0 105.00 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 0 0 105.00 106.00 107.00 LIVER ACQUISITION 0 0 0 0 <td< td=""><td></td><td></td><td></td><td>0</td><td>0</td><td>0</td><td>94 00</td></td<>				0	0	0	94 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97. 00 99. 00 09900 CMHC 0 0 0 0 99. 00 99. 10 09910 COFF 0 0 0 0 99. 00 100. 00 1600 188 SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 101.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUI SI TI ON 0 0 0 0 105. 00 106. 00 10600 HEART ACQUI SI TI ON 0 0 0 0 106. 00 107. 00 10700 LIVER ACQUI SI TI ON 0 0 0 0 0 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 107. 00 109. 00 PANCREAS ACQUI SI TI ON 0 0 0		C	0	-	0		•
99.00 09900 CMHC 0 0 0 0 99.00 99.10 09910 CORF 0 0 0 0 99.10 100.00 1& SERVICES-NOT APPRVD PRGM 0		C	0	0	0		•
99.10 09910 CORF 0 0 0 0 99.10 100.00 18R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 0				0	0		
101.00 HOME HEALTH AGENCY 0 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105.00 106.00 10600 HEART ACQUI SI TI ON 0 0 0 0 0 106.00 107.00 10700 LI VER ACQUI SI TI ON 0 0 0 0 107.00 107.00 106.00 106.00 107.00 107.00 10700 LI VER ACQUI SI TI ON 0 0 0 0 107.00 1070.00 108.00 108.00 108.00 0 0 0 0 108.00 109.00 109.00 109.00 0 0 0 0 0 0 0 100.00 110.00 110.00 110.00 110.00 110.00 111.00 111.00 111.00 1113.00 113.00 113.00 113.00 113.00		C	0	0	0	-	•
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105.00 106.00 10600 HEART ACQUI SI TI ON 0 0 0 0 105.00 106.00 16600 HEART ACQUI SI TI ON 0 0 0 0 106.00 107.00 LI VER ACQUI SI TI ON 0		C	0	0	0		
105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105.00 106.00 10600 HEART ACQUI SI TI ON 0 0 0 0 0 106.00 107.00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 107.00 108.00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 108.00 109.00 PANCREAS ACQUI SI TI ON 0 0 0 0 109.00 110.00 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 109.00 111.00 INTESTI NAL ACQUI SI TI ON 0 0 0 0 110.00 111.00 INTESTI NAL ACQUI SI TI ON 0 0 0 0 111.00 113.00 INTEREST EXPENSE 0 0 0 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00		C	0	0	0	0	101.00
107.00 10700 LIVER ACQUISITION 0 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 0 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 0 0 109.00 100.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 ISLET ACQUISITION 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00		C	0	0	0	0	105.00
108.00 10800 LUNG ACQUI SI TI ON 0 0 0 108.00 109.00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 109.00 110.00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 110.00 111.00 11100 I SLET ACQUI SI TI ON 0 0 0 0 111.00 113.00 11300 I NTEREST EXPENSE 0 0 113.00 113.00		C	0	0	0		
109.00 PANCREAS ACQUISITION 0 0 0 0 109.00 110.00 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 ISLET ACQUISITION 0 0 0 0 111.00 113.00 INTEREST EXPENSE 0 0 0 113.00				0	0		
111.00 11100 I SLET ACQUI SI TI ON 0 0 0 111.00 113.00 11300 I NTEREST EXPENSE 0 0 0 113.00			0	0	0		•
113. 00 11300 I NTEREST EXPENSE 113. 00		C	0	0	0		•
		C	0	0	0	0	
							•

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2020	Worksheet B Part I	
				To 12/31/2020	Date/Time Pre	
					7/29/2021 3:2	7 pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	234, 195	376, 173	331, 08	3 495, 392	266, 096	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		9 0	0	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194.0007950 SPECIALTY CLINICS / MOB	68, 349	0		0 0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	302, 544	376, 173	331, 09	2 495, 392	266, 096	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	STARKE MEMORIA		CN: 15-0102	In Lie Period:	u of Form CMS-2552-10 Worksheet B
				1	From 01/01/2020 To 12/31/2020	Part I Date/Time Prepared:
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	Total t	7/29/2021 3:27 pm
		17.00	24.00	25.00	26.00	
1 00	GENERAL SERVICE COST CENTERS			1		1.00
1.00 2.00 4.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT					1.00 2.00 4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT					5.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY					9.00 10.00
	01100 CAFETERI A					11.00
	01300 NURSING ADMINISTRATION					13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY					14.00 15.00
	01600 MEDICAL RECORDS & LIBRARY					16.00
17.00	01700 SOCIAL SERVICE	49,077				17.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	49,077	2, 720, 389		0 2, 720, 389	30.00
	03100 I NTENSI VE CARE UNI T	49,077	2, , 20, 30, C		0 2,720,307	31.00
	04000 SUBPROVIDER - IPF	0	C		0 0	40.00
	04100 SUBPROVI DER – I RF 04300 NURSERY	0	C		0 0 0 0	41.00 43.00
43.00	ANCI LLARY SERVICE COST CENTERS			<u>/</u>	0 0	43.00
	05000 OPERATI NG ROOM	0	1, 621, 894		0 1, 621, 894	50.00
	05100 RECOVERY ROOM	0	C		0 0	51.00
	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	7, 940		0 7,940	52.00 53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	1, 254, 716		0 1, 254, 716	54.00
	05401 ULTRASOUND	0	139, 507	7	0 139, 507	54.01
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	C 56, 062		0 0 0 56,062	55.00 56.00
	05700 CT SCAN	0	195, 230		0 195, 230	57.00
	05800 MRI	0	129, 790		0 129, 790	58.00
	05900 CARDIAC CATHETERIZATION 06000 LABORATORY	0	1 715 445		0	59.00 60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	1, 715, 465 C		0 1, 715, 465 0 0	62.00
	06400 I NTRAVENOUS THERAPY	0	C		0 0	64.00
		0	621, 758		0 621, 758	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	775, 628	5	0 775, 628 0 0	66.00 67.00
	06800 SPEECH PATHOLOGY	0	C		0 0	68.00
	06900 ELECTROCARDI OLOGY	0	240, 120		0 240, 120	69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0 14, 263		0 0 0 14, 263	70.00 71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	16, 054		0 16, 054	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 031, 336	b	0 1, 031, 336	73.00
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	C		0 0	74.00 75.00
	03030 ANGI OCARDI OGRAPHY	0	C		0 0	75.00
	OUTPATIENT SERVICE COST CENTERS			1		
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C			88. 00 89. 00
	09000 CLINIC	0	C.	þ	0 0	90.00
	09100 EMERGENCY	0	2, 477, 762	2	0 2, 477, 762	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
94.00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS	0			0 0	94.00
	09500 AMBULANCE SERVICES	0	C		0 0	95.00
	09600 DURABLE MEDI CAL EQUI P-RENTED	0	C		0 0	96.00
	09700 DURABLE MEDICAL EQUIP-SOLD 09900 CMHC	0	C			97.00 99.00
	09910 CORF	0	C	þ	o o	99.00
100.00	10000 I &R SERVICES-NOT APPRVD PRGM	0	C		0 0	100.00
101.00	10100 HOME HEALTH AGENCY	0	C		0 0	101.00
105.00	SPECIAL PURPOSE COST CENTERS 10500 KI DNEY ACQUI SI TI ON	0	C		0 0	105.00
	10600 HEART ACQUI SI TI ON	0	C		0 0	106.00
	10700 LIVER ACQUISITION	0	C		0 0	107.00
	10800 LUNG ACQUISITION	0	C	7	U 0	108.00
			ſ			100 00
109.00	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION	0	C		0 0 0 0	109.00 110.00

Health Financial Systems	AL HOSPITAL		In Lie	In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2020 To 12/31/2020		
Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	Total t		
	17.00	24.00	25.00	26.00		
113.00 11300 I NTEREST EXPENSE 114.00 11400 UTI LI ZATI ON REVI EW-SNF					113.00 114.00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	115.00	
116. 00 11600 HOSPI CE	0	0		0 0	116.00	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	49, 077	13, 017, 914		0 13, 017, 914	118.00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	35, 809		0 35, 809	190.00	
191. 00 19100 RESEARCH	0	0		0 0	191.00	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	9		0 9	192.00	
193.00 19300 NONPALD WORKERS	0	0		0 0	193.00	
194.0007950 SPECIALTY CLINICS / MOB	0	1, 415, 966		0 1, 415, 966	194.00	
200.00 Cross Foot Adjustments		0		0 0	200.00	
201.00 Negative Cost Centers	0	0		0 0	201.00	
202.00 TOTAL (sum lines 118 through 201)	49, 077	14, 469, 698		0 14, 469, 698	202.00	

	Financial Systems TION OF CAPITAL RELATED COSTS	STARKE MEMORI	AL HOSPITAL Provider C	F	In Lie Period: from 01/01/2020 o 12/31/2020	J of Form CMS-2552- Worksheet B Part II Date/Time Prepared 7/29/2021 3:27 pm	
			CAPI TAL REI	ATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS			1			
1.00 2.00 4.00 5.00 7.00 8.00 9.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE		600 20, 309 69, 536 0 7 305		60, 780 208, 101 0	1, 796 246 0 118	5.00 7.00
9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00	00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE		7, 385 7, 806 2, 128 981 4, 995 3, 414 2, 814 0	15, 555 4, 240 1, 955 9, 955	23, 361 6, 368 2, 936 14, 950 10, 218 8, 422	61 13 36 66 20 66 15 7	10.00 11.00 13.00 14.00 15.00
30. 00 31. 00 40. 00 41. 00 43. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04300 NURSERY	0 0 0 0	27, 960 0 0 0 0	55, 719 C C C C		246 0 0 0 0 0	31.00 40.00 41.00
50. 00 51. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05100 RECOVERY ROOM	0	30, 397 0	60, 574 C	90, 971	103 0	1
52.00 53.00 54.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	000000000000000000000000000000000000000	0 0 12, 906	C C 25, 718	0 0 0 0 3 38, 624	0 0 126	53.00
54. 01 55. 00 56. 00	05401 ULTRASOUND 05500 RADI OLOGY - THERAPEUTI C 05600 RADI OI SOTOPE	0 0 0	0 0 0			20 0 3	55.00 56.00
57.00 58.00 59.00	05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0 0 0	1, 725 4, 550 0	3, 438 9, 067 C	13, 617 0 0	14 5 0	57.00 58.00 59.00
60.00 62.00 64.00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06400 INTRAVENOUS THERAPY	000000000000000000000000000000000000000	7, 051 0 0	14, 051 C	0 0 0 0	152 0 0	62.00
65.00 66.00 67.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	000000000000000000000000000000000000000	3, 055 7, 712 0	15, 369 C	23, 081 0 0	87 90 0	67.00
69. 00 70. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	000000000000000000000000000000000000000	0 1, 581 0	C 3, 151 C	-	0 30 0	69.00 70.00
73.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 0 0	0 0 0			0 0 0	72.00 73.00
74.00 75.00 76.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 03030 ANGI 0CARDI 0GRAPHY	0 0 0	0 0 0			0 0 0	75.00
	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	000000000000000000000000000000000000000	0 0 0	C C C		0 0 0	89.00 90.00
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0	14, 695	29, 284	43, 979	272	92.00
100.00	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD 09900 CMHC 09910 CORF 10000 I &R SERVI CES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY		0 0 0 0 0 0 0 0 0				97.00 99.00
105.00 106.00 107.00 108.00	SPECIAL PURPOSE COST CENTERS 10500 KI DNEY ACQUI SI TI ON 10600 HEART ACQUI SI TI ON 10700 LI VER ACQUI SI TI ON 10800 LUNG ACQUI SI TI ON 10900 PANCREAS ACQUI SI TI ON		000000000000000000000000000000000000000			0 0 0 0	105.00 106.00 107.00 108.00 109.00
	11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0		1109.00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provider CCN: 15-01			Period: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Pre 7/29/2021 3:2	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
111.00 11100 I SLET ACQUI SI TI ON 113.00 11300 I NTEREST EXPENSE	0	0		0 0	0	111. 00 113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		115.00
116. 00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	231, 600	461, 52	5 693, 125	1, 796	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 790	3, 56	7 5, 357		190.00
191. 00 19100 RESEARCH	0	0		0 0	-	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194.0007950 SPECIALTY CLINICS / MOB	0	67, 357	134, 22	6 201, 583	0	194.00
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	300, 747	599, 31	8 900, 065	1, 796	202.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	STARKE MEMORI	AL HOSPITAL Provider C		eriod: rom 01/01/2020	u of Form CMS-2 Worksheet B Part II Date/Time Pre 7/29/2021 3:2	pared:
Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	/ piii
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.00 00100 CAP REL COSTS-BLDG & FTAT 2.00 00200 CAP REL COSTS-MVBLE EQUI P 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LIBRARY 17.00 00700 SOCIAL SERVICE COST CENTERS	61, 026 11, 105 706 2, 471 623 1, 134 1, 491 1, 037 1, 821 911 185	219, 206 0 7, 698 8, 136 2, 218 1, 023 5, 207 3, 559 2, 933 0	824 0 10 0 0 0 0 0 0	32, 332 1, 244 339 156 796 544 448 0	33, 387 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00 \end{array}$
30. 00 03000 ADULTS & PEDIATRICS	7,086	29, 144	190	4, 455	33, 387	30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0 0 0 0	0 0 0 0	0 0 0	0 0 0 0	000000000000000000000000000000000000000	31. 00 40. 00 41. 00 43. 00
50. 00 05000 OPERATI NG ROOM	3, 982	31, 684		4, 843	0	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY State State State 54.00 05400 RADI OLOGY-DI AGNOSTI C State State State State	0 0 5 4,074 537	0 0 0 13, 452 0		0 0 2, 056 0	0 0 0 0 0	51.00 52.00 53.00 54.00 54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN 58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI 0N 60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	206 507 205 0 5, 874 0	0 1, 798 4, 742 0 7, 350 0	0 0 0	0 275 725 0 1, 124 0	0 0 0 0 0 0	56.00 57.00 58.00 59.00 60.00 62.00
64.00 06400 I NTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY	0 2, 318 2, 612 0	0 3, 184 8, 039 0	0 14 25	0 487 1, 229	0 0 0	64. 00 65. 00 66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0 0 829	0 0 1, 648	0	0 0 252	0 0 0	68. 00 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0 56 65	0 0 0	0 0 0	0 0 0	0 0 0	70.00 71.00 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S	2, 142 0	0	0	0	0	73.00 74.00
75. 00 07500 ASC (NON-DI STI NCT PART) 76. 00 03030 ANGI OCARDI OGRAPHY	0	0	0	0	0	75.00 76.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	0 0 0	0	0 0 0	0 0 0	88.00 89.00 90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	7, 836	15, 317	361	2, 341	0	91.00 92.00
0THER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVI CES	0	0	0	Ō	0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0	0	0	96.00 97.00
99. 00 09900 CMHC	0	0	0	0	0	99.00 99.00
99. 10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0		100. 00 101. 00
105.00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0		105.00
106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	0		106. 00 107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	Ō	0	108. 00
109. 00 10900 PANCREAS ACQUI SI TI ON 110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0 0		0		109. 00 110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0		111.00
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF						113. 00 114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00

Health Finar	icial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION	OF CAPITAL RELATED COSTS		Provider CC		Period:	Worksheet B	
					rom 01/01/2020	Part II	
					To 12/31/2020	Date/Time Pre	
	· · · · · · · · · · · ·					7/29/2021 3:2	/ pm
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7.00	8.00	9.00	10.00	
116.0011600	HOSPI CE	0	0	(0 0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	59, 818	147, 132	824	1 21, 314	33, 387	118.00
NONRE	IMBURSABLE COST CENTERS						
190.0019000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31	1, 866	() 285	0	190. 00
191.0019100	RESEARCH	0	0	(0 0	0	191.00
192.0019200	PHYSICIANS' PRIVATE OFFICES	0	0	(0 0	0	192.00
193.0019300	NONPAID WORKERS	0	0	(0 0	0	193.00
194.0007950	SPECIALTY CLINICS / MOB	1, 177	70, 208	(10, 733	0	194.00
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	(0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	61, 026	219, 206	824	32, 332	33, 387	202.00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 01/01/2020	Worksheet B Part II	
			To		Date/Time Pre 7/29/2021 3:2	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
	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 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT						5.00 7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	10, 095					10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	236					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	199	0	22, 209			14.00
	306	1	20	16, 534	10,000	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	177		16 0	0	12, 922 0	16.00 17.00
INPATIENT ROUTINE SERVICE COST CENTERS		1	-	1		
30. 00 03000 ADULTS & PEDIATRICS	1, 475	· · ·	1, 804	0	750	30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF	0	-	0	0	0	31.00 40.00
41. 00 04100 SUBPROVIDER - IRF	0	0	0	Ő	0	41.00
43. 00 04300 NURSERY	0	0	0	0	0	43.00
ANCI LLARY SERVI CE COST CENTERS	592	802	5, 287	0	1, 464	50.00
51. 00 05100 RECOVERY ROOM	0		0,207	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	-	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	736	-	14 1, 232	0	320 694	53.00 54.00
54. 01 05401 ULTRASOUND	104		134	0	339	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN	13		324 709	0	92	56.00
57. 00 05700 CT_SCAN 58. 00 05800 MRI	77		25	0	1, 681 386	57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	1	0	0	0	59.00
	1,077	1	8, 348	0	2, 509	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 64.00 06400 INTRAVENOUS THERAPY	0		0	0	0	62.00 64.00
65. 00 06500 RESPI RATORY THERAPY	535		190	0	99	65.00
66. 00 06600 PHYSI CAL THERAPY	638	1	62	0	428	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0		0	0	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	185	Ŭ	63	0	531	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	53 30	71.00 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	16, 534	1, 363	
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75. 00 07500 ASC (NON-DI STI NCT PART) 76. 00 03030 ANGI OCARDI OGRAPHY	0		0	0	0	75.00 76.00
OUTPATIENT SERVICE COST CENTERS	0	<u> </u>	0	0	0	70.00
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	0	0	0	0	89.00 90.00
91. 00 09100 EMERGENCY	1, 405	2, 615	3, 980	0	2, 183	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REI MBURSABLE COST CENTERS			0	0	0	
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	94.00 95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99. 00 09900 CMHC 99. 10 09910 CORF	0		0	0	0	99.00 99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS	0		0	0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	0		107.00
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION	0	0	0	0		108. 00 109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		1109.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	О	0	111.00
113.00 11300 INTEREST_EXPENSE 114.00 11400 UTILIZATION_REVIEW-SNF	1					113.00 114.00
	1					00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period:	Worksheet B	
				From 01/01/2020 To 12/31/2020		narod
				10 12/31/2020	7/29/2021 3:2	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	0	115.00
116. 00 11600 H0SPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 814	5, 908	22, 20	8 16, 534	12, 922	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		1 0	0	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194.0007950 SPECIALTY CLINICS / MOB	2, 281	0		0 0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	10, 095	5, 908	22, 20	9 16, 534	12, 922	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	STARKE MEMORIA			Period:	u of Form CMS-2552-10 Worksheet B
					From 01/01/2020 To 12/31/2020	Part II Date/Time Prepared:
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total t	7/29/2021 3:27 pm
		17.00	24.00	25.00	26.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1			1	1.00
2.00	00200 CAP REL COSTS-BEDG & FIXT					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMINI STRATI VE & GENERAL					5.00
7.00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY					9. 00 10. 00
	01100 CAFETERI A					11.00
	01300 NURSI NG ADMI NI STRATI ON					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
	01500 PHARMACY					15.00
	01600 MEDICAL RECORDS & LIBRARY	204				16.00
17.00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	294				17.00
30.00	03000 ADULTS & PEDIATRICS	294	164, 850		164, 850	30.00
	03100 I NTENSI VE CARE UNI T	0	01,000		0 0	31.00
40.00	04000 SUBPROVI DER – I PF	0	0) (o o	40.00
	04100 SUBPROVI DER – I RF	0	C) (-	41.00
43.00	04300 NURSERY	0	0) (0 0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	139, 815		139, 815	50.00
	05100 RECOVERY ROOM	0	139,013			51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	52.00
53.00	05300 ANESTHESI OLOGY	0	339) (339	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	61, 155		0.,.00	54.00
	05401 ULTRASOUND	0	1, 134		.,	54.01
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0 638		0 0 0 638	55.00 56.00
57.00	05700 CT SCAN	0	10, 227			57.00
	05800 MRI	0	19, 729		19, 729	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C) (59.00
	06000 LABORATORY	0	47, 577		0 47, 577	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	62.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	16, 057			64.00 65.00
	06600 PHYSI CAL THERAPY	0	36, 204		0 16,057 0 36,204	66.00
	06700 OCCUPATI ONAL THERAPY	0	00,201		0 0	67.00
	06800 SPEECH PATHOLOGY	0	C) (o c	68.00
	06900 ELECTROCARDI OLOGY	0	8, 286	. (0 8, 286	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	109 95		0 109 0 95	71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS	0	20, 039		20, 039	72.00
	07400 RENAL DIALYSIS	0	0		0 0	74.00
	07500 ASC (NON-DISTINCT PART)	0	C) (0 0	75.00
76.00		0	C) (0 0	76.00
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0			88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			89.00
	09000 CLINIC	0	0		o o	90.00
	09100 EMERGENCY	0	80, 289		80, 289	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92.00
04.00	OTHER REIMBURSABLE COST CENTERS					
	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0	0			94.00 95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0			95.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	C C		o o	97.00
	09900 СМНС	0	0		o o	99.00
	09910 CORF	0	C		0 0	99.10
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0	100.00
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	η (0	101.00
101.00	SI ESTAE I UNI USE UUSI ULIVIENS		0) (n l	105.00
	10500 KIDNEY ACQUISITION					
105.00	10500 KI DNEY ACQUI SI TI ON 10600 HEART ACQUI SI TI ON	0	C) (lo c	106.00
105.00 106.00 107.00	10600 HEART ACQUISITION 10700 LIVER ACQUISITION	0	C			106. 00 107. 00
105.00 106.00 107.00 108.00	10600 HEART ACQUISITION 10700 LIVER ACQUISITION 10800 LUNG ACQUISITION	0	C C C		0 0 0 0 0 0	107. 00 108. 00
105.00 106.00 107.00 108.00 109.00	10600 HEART ACQUISITION 10700 LIVER ACQUISITION					107.00

Health Financial Systems	STARKE MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period:	Worksheet B
				From 01/01/2020 To 12/31/2020	Part II Date/Time Prepared:
					7/29/2021 3:27 pm
Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern &	Total	
			Residents Cos	t	
			& Post Stepdown		
			Adjustments		
	17.00	24.00	25.00	26.00	
113.00 11300 INTEREST EXPENSE					113.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF					114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	115.00
116. 00 11600 HOSPI CE	0	0		0 0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	294	606, 543		0 606, 543	118.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7, 539		0 7, 539	
191. 00 19100 RESEARCH	0	0		0 0	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	1		0 1	192.00
193. 00 19300 NONPALD WORKERS	0			0 0	193.00 194.00
194.00 07950 SPECIALTY CLINICS / MOB 200.00 Cross Foot Adjustments	0	285, 982		0 285, 982	200.00
201.00 Negative Cost Centers	0	0		0 0	200.00
202.00 TOTAL (sum lines 118 through 201)	294	900, 065		0 900, 065	201.00
	274	700, 005	I	oj 300, 005	202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	STARKE MEMORI	AL HOSPITAL Provider CO	CN: 15-0102 P	eriod:	u of Form CMS-: Worksheet B-1	
					rom 01/01/2020 o 12/31/2020		
		CAPI TAL REI	ATED COSTS			7/29/2021 3:2	/ pm
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	83, 683					1.00
2.00 4.00 5.00 7.00 8.00 9.00	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	167 5, 651 19, 348 0 2, 055	83, 683 167 5, 651 19, 348 0	6, 407, 876 877, 518 0 422, 463 217, 100	-4, 014, 538 0 0	10, 455, 160 1, 902, 852 121, 026 423, 307	2.00 4.00 5.00 7.00 8.00
9.00 10.00 11.00 13.00 14.00 15.00 16.00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	2, 053 2, 172 592 273 1, 390 950 783	2, 172 592 273	47, 907 47, 997 128, 889 234, 363 71, 558 237, 385 53, 171	0 0 0 0	423, 307 106, 686 194, 216 255, 449 177, 659 311, 953 156, 007	10.00 11.00 13.00 14.00 15.00
17.00	01700 SOCIAL SERVICE	0	0	25, 659	0	31, 614	17.00
30.00 31.00 40.00 41.00 43.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY ANCILLARY SERVICE COST CENTERS	7, 780 0 0 0	7, 780 0 0 0 0	878, 809 0 0 0 0	0 0 0	1, 214, 026 0 0 0 0	30.00 31.00 40.00 41.00 43.00
50.00	05000 OPERATI NG ROOM	8, 458	8, 458	367, 865	0	682, 200	50.00
$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 62.\ 00\\ \end{array}$	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0 0 3, 591 0 0 480 1, 266 0 1, 962	0 0 3, 591 0 0 480 1, 266 0 1, 962	0 0 451, 322 70, 228 0 10, 013 49, 759 16, 884 0 541, 787		0 825 697, 909 92, 052 0 35, 372 86, 789 35, 067 0 1, 006, 410 0	54.00 54.01 55.00 56.00 57.00 58.00 59.00
64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 OCCUPATI ONAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 03030 ANGI OCARDI OGRAPHY 0UTPATI ENT SERVI CE COST CENTERS	0 0 850 2, 146 0 440 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		311, 177 320, 143 0 108, 378 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 397, 088 447, 532 0 142, 023 0 9, 519 11, 152 366, 941 0 0 0	64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 72.00
88.00 89.00 90.00 91.00 92.00	09000 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0 0 0 4, 089	0 0 4, 089	0 0 965, 408	0	0 0 1, 342, 546	88.00 89.00 90.00 91.00 92.00
100.00	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD 09900 CMHC 09910 CORF 10000 I &R SERVI CES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	94.00 95.00 96.00 97.00 99.00 99.10 100.00 101.00
106.00 107.00 108.00	SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION 10700 LIVER ACQUISITION 10800 LUNG ACQUISITION 10900 PANCREAS ACQUISITION				0 0 0 0 0	0 0 0	105.00 106.00 107.00 108.00 109.00

COST ALLOCATION - STATISTICAL BASIS						
		Provider C	F	Period: From 01/01/2020	Worksheet B-1	
				To 12/31/2020	Date/Time Pre 7/29/2021 3:2	
	CAPI TAL REI	ATED COSTS				
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
			DEPARTMENT (GROSS		(ACCUM. COST)	
			SALARI ES)			
	1.00	2.00	4.00	5A	5.00	
110.00 11000 INTESTINAL ACQUISITION	0	0	(0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	(0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	(115.00
116.00 11600 HOSPI CE	0	0	(, · · · · ·		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117 NONREI MBURSABLE COST CENTERS) 64, 443	64, 443	6, 407, 876	-4, 014, 538	10, 248, 220	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	498	498	(5 257	190.00
191. 00 19100 RESEARCH	470	490		-		191.00
192. 0019200 PHYSICIANS' PRIVATE OFFICES	0					192.00
193. 00 19300 NONPALD WORKERS	0	0		0		193.00
194.0007950 SPECIALTY CLINICS / MOB	18, 742	18, 742		0 0	201, 583	
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)	300, 747	599, 318	1, 008, 495	5	4, 014, 538	202.00
203.00 Unit cost multiplier (Wkst. B, Part I) 3. 593884	7. 161765	0. 157384	1	0. 383977	203.00
204.00 Cost to be allocated (per Wkst. B,			1, 796	b	61, 026	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part			0. 000280)	0. 005837	205.00
206.00 NAHE adjustment amount to be allocate (per Wkst. B-2)	d					206. 00
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

Health Financial		STARKE MEMORI				u of Form CMS-2	2552-10
COST ALLOCATION -	STATI STI CAL BASI S		Provider C	F	eriod: rom 01/01/2020 o 12/31/2020	Worksheet B-1 Date/Time Pre	nared [.]
						7/29/2021 3:2	
Cost	Center Description	OPERATION OF PLANT (SQUARE FEET)	(POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (FTE)	
		7.00	LAUNDRY) 8.00	9.00	10.00	11.00	
	RVICE COST CENTERS	1					
1 1	REL COSTS-BLDG & FIXT						1.00
	REL COSTS-MVBLE EQUIP DYEE BENEFITS DEPARTMENT						2.00 4.00
	II STRATI VE & GENERAL						5.00
1 1	ATION OF PLANT	58, 517					7.00
1 1	DRY & LINEN SERVICE	0	64, 920				8.00
9.00 00900 HOUSE 10.00 01000 DI ETA		2,055	0		4 150		9.00
11.00 01100 CAFET		2, 172	760	2, 172 592	6, 158 0	8, 729	10.00 11.00
	NG ADMI NI STRATI ON	273	0	273	0	204	13.00
14.00 01400 CENTR	RAL SERVICES & SUPPLY	1, 390	0	1, 390	0	172	14.00
15.00 01500 PHARM		950	0	950	0	265	15.00
16.00 01600 MEDIC 17.00 01700 SOCIA	CAL RECORDS & LIBRARY	783	0	783	0	153 30	16.00 17.00
	ROUTINE SERVICE COST CENTERS	0	0	0	<u> </u>	50	17.00
	S & PEDIATRICS	7, 780	14, 941	7, 780	6, 158	1, 275	30.00
	ISI VE CARE UNI T	0	0	0	0	0	31.00
	ROVIDER - IPF	0	0	0	0	0	40.00
41.00 04100 SUBPF 43.00 04300 NURSE	ROVIDER – IRF	0	0	0	0	0	41.00 43.00
	SERVICE COST CENTERS		0				10.00
50.00 05000 0PERA		8, 458	6, 855	8, 458	0	512	50.00
51.00 05100 RECOV		0	0	0	0	0	51.00
	VERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANEST 54.00 05400 RADIO	DLOGY-DI AGNOSTI C	3, 591	10, 782	3, 591	0	0 636	53.00 54.00
54.01 05401 ULTRA		3, 341	10, 782	3, 341	0	90	54.00
	DLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00 05600 RADI 0		0	0	0	0	11	56.00
57.00 05700 CT SC	CAN	480	0	480	0	67	57.00
58.00 05800 MRI 59.00 05900 CARDI		1,266	0	1, 266	0	21	58.00
60. 00 06000 LABOR	AC CATHETERI ZATI ON	1, 962		1, 962	0	0 931	59.00 60.00
	BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00 06400 I NTRA	VENOUS THERAPY	0	0	0	0	0	64.00
	RATORY THERAPY	850	1, 090		0	463	65.00
	CAL THERAPY PATIONAL THERAPY	2, 146	1,947	2, 146 0	0	552 0	66.00 67.00
	CH PATHOLOGY	0			0	0	68.00
	ROCARDI OLOGY	440	0	440	0	160	
70.00 07000 ELECT	ROENCEPHALOGRAPHY	0	0	0	0	0	70.00
	CAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
	DEV. CHARGED TO PATIENTS CHARGED TO PATIENTS	0	0	0	0	0	72.00 73.00
74.00 07400 RENAL		0			0	0	73.00
	(NON-DISTINCT PART)	0	0	0	0	0	75.00
	CARDI OGRAPHY	0	0	0	0	0	76.00
	SERVICE COST CENTERS						00.00
	_ HEALTH CLINIC RALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88.00 89.00
90.00 09000 CLINI		0	0	0	0	0	90.00
91.00 09100 EMERG		4,089	28, 545	4, 089	0	1, 215	91.00
	VATION BEDS (NON-DISTINCT PART						92.00
	BURSABLE COST CENTERS						04.00
94.00 09400 HOME 95.00 09500 AMBUL	PROGRAM DI ALYSI S	0	0	0	0	0	94.00 95.00
	BLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
	BLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99.00 09900 CMHC		0	0	0	0	0	99.00
99.10 09910 CORF	COVERED NOT ADDDVD DDCM	0	0	0	0	0	99.10
101.00 10100 HOME	SERVICES-NOT APPRVD PRGM	0		0	0		100. 00 101. 00
	RPOSE COST CENTERS		0	0	<u> </u>	0	101.00
105.00 10500 KI DNE	Y ACQUISITION	0	0	0	0		105. 00
106.00 10600 HEART		0	0	0	0		106.00
107.00 10700 LI VEF		0	0	0	0		107. 00 108. 00
108.00 10800 LUNG 109.00 10900 PANCE					0		108.00 109.00
	STINAL ACQUISITION	0	0	0	0		110.00
111.00 11100 I SLET	ACQUI SI TI ON	0	0	0	0		111.00
113.00 11300 I NTER	REST EXPENSE						113.00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2020	Worksheet B-1	
				o 12/31/2020	Date/Time Pre	pared:
					7/29/2021 3:2	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(FTE)	
	(SQUARE FEET)	(POUNDS OF				
		LAUNDRY)				
	7.00	8.00	9.00	10.00	11.00	
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	C	0 0	0	115.00
116. 00 11600 HOSPI CE	0	0 0	C	0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	39, 277	64, 920	37, 222	6, 158	6, 757	118.00
NONREI MBURSABLE COST CENTERS	<u>.</u>	•				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	498	0	498	8 0	0	190.00
191. 00 19100 RESEARCH	0	0	C	0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0	0	192.00
193. 00 19300 NONPALD WORKERS	0	0	C	0	0	193.00
194.0007950 SPECIALTY CLINICS / MOB	18, 742	0	18, 742	0	1, 972	194.00
200.00 Cross Foot Adjustments			1			200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	2, 633, 500	167, 497	678, 330	273, 455	302, 544	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	45.004016	2. 580052	12.013921	44.406463	34.659640	203.00
204.00 Cost to be allocated (per Wkst. B,	219, 206	824	32, 332	33, 387	10, 095	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	3. 746023	0. 012693	0. 572633	5. 421728	1. 156490	205.00
11)						
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

	Financial Systems LOCATION - STATISTICAL BASIS	STARKE MEMORIA	AL HOSPITAL Provider CO	N: 15-0102	In Lie Period:	u of Form CMS- Worksheet B-1	
COST AL	LUCATION - STATISTICAL DASIS			F	From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		7/29/2021 3:2 SOCI AL SERVI CE	
		ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUI S.)	RECORDS & LI BRARY	(TIME SPENT)	
		(TOTAL NURS ING SALAR)	(COSTED REQUI S.)		(GROSS CHAR GES)		
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	
	DO100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	DO200 CAP REL COSTS-MVBLE EQUIP						2.00
	DO400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	DOTOO OPERATION OF PLANT						5.00 7.00
	DO800 LAUNDRY & LINEN SERVICE						8.00
	DO900 HOUSEKEEPING						9.00
	01000 DI ETARY 01100 CAFETERI A						10.00
	D1300 NURSI NG ADMI NI STRATI ON	2,096,117					13.00
	01400 CENTRAL SERVICES & SUPPLY	0	592, 960				14.00
		0	544	373, 937			15.00
	D1600 MEDI CAL RECORDS & LI BRARY D1700 SOCI AL SERVI CE	23, 870	426 0			1, 520	16.00 17.00
	NPATIENT ROUTINE SERVICE COST CENTERS	20,0,0				., 020	
	03000 ADULTS & PEDI ATRI CS	830, 135	48, 156	(.,	1, 520	1
	D3100 I NTENSI VE CARE UNI T D4000 SUBPROVI DER – I PF	0	0	(0	
	04100 SUBPROVIDER - IRF	0	0			0	
43.00	D4300 NURSERY	0	0	(0	0	
	ANCI LLARY SERVICE COST CENTERS	204 402	1 4 1 1 5 1				
	D5000 OPERATING ROOM D5100 RECOVERY ROOM	284, 483	141, 151 0	(0	
	D5200 DELIVERY ROOM & LABOR ROOM	0	0	(0 0	0	52.00
	D5300 ANESTHESI OLOGY	0	364	(1, 719, 668	0	53.00
	D5400 RADI OLOGY-DI AGNOSTI C D5401 ULTRASOUND	8,632	32, 882 3, 569		3, 729, 748 1, 824, 439	0	54.00 54.01
	05500 RADI OLOGY-THERAPEUTI C	0	3, 509		0 1, 824, 439	0	
56.00 0	D5600 RADI OI SOTOPE	0	8, 651	(494, 536	0	56.00
	D5700 CT SCAN	1, 131	18, 928	(.,	0	
	D5800 MRI D5900 CARDI AC CATHETERI ZATI ON	0	679 0		2,077,213	0	58.00 59.00
	D6000 LABORATORY	14, 526	222, 946	(13, 401, 537	0	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(0 0	0	62.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0 5, 072	() 0 532, 323	0	
	D6600 PHYSI CAL THERAPY	0	1, 649	(2, 299, 211	0	66.00
	06700 OCCUPATI ONAL THERAPY	0	0	(0 0	0	67.00
	06800 SPEECH PATHOLOGY	0	0			0	
	D6900 ELECTROCARDI OLOGY D7000 ELECTROENCEPHALOGRAPHY	5, 803	1, 671 0		2, 856, 582	0	07.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(283, 961	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	161, 737	0	
	07300 DRUGS CHARGED TO PATLENTS 07400 RENAL DLALYSES	0	0	373, 937	7, 328, 831	0	
	D7500 ASC (NON-DI STI NCT PART)	0	0	(0 0	0	
	03030 ANGI OCARDI OGRAPHY	0	0	(0 0	0	76.00
	DUTPATIENT SERVICE COST CENTERS	0	0	(0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0 0	0	
	09000 CLINIC	0	0	C	0 0	0	
	D9100 EMERGENCY D9200 OBSERVATION BEDS (NON-DISTINCT PART	927, 537	106, 255	(11, 738, 453	0	91.00 92.00
	THER REIMBURSABLE COST CENTERS	<u> </u>					92.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	(0 0	0	
	09500 AMBULANCE SERVICES	0	0	(0	0	
	09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0			0	
	09900 CMHC	0	0	(0 0	0	
	09910 CORF	0	0	(0 0	0	
	10000 I&R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0	0				100.00 101.00
	SPECIAL PURPOSE COST CENTERS	0	0		0	0	101.00
105.00	10500 KIDNEY ACQUISITION	0	0	(0 0		105.00
	10600 HEART ACQUI SI TI ON	0	0				106.00
	10700 LIVER ACQUISITION 10800 LUNG ACQUISITION	0	0				107.00 108.00
	10900 PANCREAS ACQUISITION	0	0		0	0	109. 00
	11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00	11100 I SLET ACQUI SI TI ON	0	0	(ס וי	0	111.00

Health Financial Systems	STARKE MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC	CN: 15-0102	Peri od:	Worksheet B-1	
				From 01/01/2020 To 12/31/2020		narod
				10 12/31/2020	7/29/2021 3:2	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
		SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
	(TOTAL NURS	(COSTED		(GROSS CHAR		
	ING SALAR)	REQUIS.)	45.00	GES)	17.00	
	13.00	14.00	15.00	16.00	17.00	112.00
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF						113.00 114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	0	115.00
116. 00 11600 H0SPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2,096,117	592, 943	373, 93	69, 388, 487		118.00
NONREI MBURSABLE COST CENTERS	2,070,117	572, 745	575,75	<i>ii</i> 07, 300, 407	1, 520	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	17		0 0	0	192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194.0007950 SPECIALTY CLINICS / MOB	0	0		0 0	0	194.00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	376, 173	331, 092	495, 39	2 266, 096	49, 077	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 179462	0. 558372				
204.00 Cost to be allocated (per Wkst. B, Part II)	5, 908	22, 209	16, 53	12, 922	294	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0.002819	0. 037454	0. 04421	6 0.000186	0. 193421	205.00
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)		l			I	I

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Peri od:	Worksheet C	
				From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	pared:
		Ti +L c	× XVIII	Hospi tal	7/29/2021 3:2 PPS	7 pm
				Costs	PP3	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B, Part I, col.	Adj .		Di sal I owance		
	26)					
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	2, 720, 389		2, 720, 38		2, 720, 389	30,00
31. 00 03100 NTENSI VE CARE UNI T	2, 720, 307		2,720,30	0 0	2, 720, 307	1
40. 00 04000 SUBPROVI DER – I PF	0			0 0	0	
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	0			0 0 0 0	0	
ANCI LLARY SERVICE COST CENTERS	0			0 0	0	43.00
50. 00 05000 OPERATI NG ROOM	1, 621, 894		1, 621, 89	4 0	1, 621, 894	50.00
51.00 05100 RECOVERY ROOM	0			0 0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	7,940		7,94	0 0	0 7, 940	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 254, 716		1, 254, 71	-	1, 254, 716	1
54. 01 05401 ULTRASOUND	139, 507		139, 50		139, 507	
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0 56,062		56, 06	0 0	0 56, 062	
57. 00 05700 CT SCAN	195, 230		195, 23		195, 230	1
58. 00 05800 MRI	129, 790		129, 79	0 0	129, 790	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1 715 445		1, 715, 46	0 0	0 1 715 445	
60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 715, 465		1, /15, 40	5 O 0 O	1, 715, 465 0	1
64. 00 06400 I NTRAVENOUS THERAPY	0			0 0	0	1
65. 00 06500 RESPI RATORY THERAPY	621, 758				621, 758	1
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	775, 628		775, 62	8 0 0 0	775, 628 0	1
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	240, 120		240, 12	0 0	240, 120	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		14.00	0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	14, 263 16, 054		14, 26 16, 05		14, 263 16, 054	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 031, 336		1, 031, 33		1, 031, 336	1
74.00 07400 RENAL DI ALYSI S	0			0 0	0	
75. 00 07500 ASC (NON-DI STI NCT PART) 76. 00 03030 ANGI OCARDI OGRAPHY	0			0 0 0 0	0	
OUTPATIENT SERVICE COST CENTERS	0			0 0	0	70.00
88.00 08800 RURAL HEALTH CLINIC	0			0 0	0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0			0 0	0	
91. 00 09100 EMERGENCY	2, 477, 762		2, 477, 76	2 0	2, 477, 762	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	362, 925		362, 92	5	362, 925	92.00
0THER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S	0	[1	0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0			0 0	0	1
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0			0 0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 99. 00 09900 CMHC	0			0 0	0	
99. 00 09900 CMHC 99. 10 09910 CORF	0			0	0	1
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0			0		100.00
101.00 10100 HOME HEALTH AGENCY	0			0	0	101.00
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON	0			0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0			0		106.00
107.00 10700 LIVER ACQUISITION	0			0		107.00
108.00 10800 LUNG ACQUISITION	0			0		108.00
109. 00 10900 PANCREAS ACQUI SI TI ON 110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0			0		109. 00 110. 00
111.00 11100 I SLET ACQUI SI TI ON	0			0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.)	0			0	0	114. 00 115. 00
116. 00 11600 H0SPI CE	0			ŏ		116.00
200.00 Subtotal (see instructions)	13, 380, 839				13, 380, 839	1
201.00Less Observation Beds202.00Total (see instructions)	362, 925		362, 92		362, 925 13, 017, 914	
202.00 Total (see instructions)	13, 017, 914	ı 0	13, 017, 91		13, 017, 914	1202.00

	Financial Systems	STARKE MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2020	Worksheet C Part I	
					To 12/31/2020	Date/Time Pre	
			Title	e XVIII	Hospi tal	7/29/2021 3:2 PPS	/ piii
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6		TEFRA	
				+ col. 7)	Ratio	Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 000 470		4 000 474			1 00 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	4, 033, 170		4, 033, 170			30.00 31.00
40.00	04000 SUBPROVIDER - IPF	0					40.00
41.00	04100 SUBPROVI DER – I RF	0		(D		41.00
43.00	04300 NURSERY	0		(ו		43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	454, 412	7, 416, 785	7, 871, 19	0. 206054	0. 000000	50.00
51.00	05100 RECOVERY ROOM	454, 412	7,410,785	7, 871, 19		0. 000000	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0. 000000	
53.00	05300 ANESTHESI OLOGY	93, 292	1, 626, 376			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	174, 424	3, 555, 324			0.00000	1
54. 01 55. 00	05401 ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C	118, 026	1, 708, 864	1, 826, 890	0.076363 0.000000	0. 000000 0. 000000	1
56.00	05600 RADI OI SOTOPE	0	494, 536	494, 536		0.000000	1
57.00	05700 CT SCAN	1, 038, 346	7, 997, 535			0.000000	1
58.00	05800 MRI	90, 737	1, 986, 476	2, 077, 213		0. 000000	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0		12 402 52	0.000000	0.00000	
60.00 62.00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 712, 017	11, 690, 520	13, 402, 53	7 0. 127996 0. 000000	0. 000000 0. 000000	1
64.00	06400 I NTRAVENOUS THERAPY	0	0		0.000000	0.000000	1
65.00	06500 RESPI RATORY THERAPY	339, 345	192, 978	532, 323		0. 000000	65.00
66.00	06600 PHYSI CAL THERAPY	220, 057	2, 079, 154			0. 000000	1
67.00	06700 OCCUPATIONAL THERAPY	0	0			0.00000	1
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	402, 158	2, 454, 424	2, 856, 582	0.000000 0.084059	0. 000000 0. 000000	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2, 101, 121	2,000,002	0.000000	0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	93, 249	190, 712	283, 96		0. 000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	161, 737			0. 000000	
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	2, 207, 302	5, 121, 529	7, 328, 83		0.00000	1
74.00 75.00	07500 ASC (NON-DI STI NCT PART)	0	0		0.000000	0. 000000 0. 000000	1
76.00	03030 ANGI OCARDI OGRAPHY	0	0			0. 000000	
	OUTPATIENT SERVICE COST CENTERS				1		
88.00	08800 RURAL HEALTH CLINIC	0	0	(88.00
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0. 000000	0. 000000	89.00 90.00
91.00	09100 EMERGENCY	1, 194, 685	10, 543, 768	11, 738, 453		0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	123, 727	137, 241			0. 000000	
04.00	OTHER REIMBURSABLE COST CENTERS			1		0,000000	
	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0	0		0. 000000 0. 000000	0. 000000 0. 000000	
	09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0.000000	0. 000000	
	09700 DURABLE MEDI CAL EQUI P-SOLD	0	C	0	0. 000000	0. 000000	
	09900 CMHC	0	0	(D		99.00
	09910 CORF 10000 I &R SERVICES-NOT APPRVD PRGM	0	0				99. 10 100. 00
	10000 FAR SERVICES-NOT APPROD PROM	0					100.00
	SPECIAL PURPOSE COST CENTERS		-	-	-		
	10500 KIDNEY ACQUISITION	0	C	(ט		105.00
	10600 HEART ACQUISITION 10700 LIVER ACQUISITION	0	0				106. 00 107. 00
	10800 LUNG ACQUISITION	0	0				107.00
	10900 PANCREAS ACQUI SI TI ON	0	0				109.00
110.00	11000 INTESTINAL ACQUISITION	0	C	0	D		110.00
	11100 I SLET ACQUI SI TI ON	0	C	(D		111.00
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF						113.00 114.00
	11400 UTILIZATION REVIEW-SNF 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	,			114.00
	11600 HOSPI CE	0	o o				116.00
200.00	Subtotal (see instructions)	12, 294, 947	57, 357, 959	69, 652, 906	5		200. 00
201.00		10 004 047		(0 (50 00)	,		201.00
202.00	Total (see instructions)	12, 294, 947	57, 357, 959	69, 652, 906		l	202.00

Health Financial Systems	STARKE MEMORIAL	L HOSPI TAL	In Lieu	」of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0102	Peri od:	Worksheet C	
			From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	epared:
		Title XVIII	Hospi tal	7/29/2021 3:2 PPS	27 pm
Cost Center Description	PPS Inpatient		nooprear		
	Rati o 11.00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	11.00				
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF					31.00 40.00
41. 00 04100 SUBPROVI DER - I RF					41.00
43.00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0. 206054				50.00
51. 00 05100 RECOVERY ROOM	0. 000000				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.004617				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ULTRASOUND	0. 336408 0. 076363				54.00 54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
56. 00 05600 RADI 0I SOTOPE	0. 113363				56.00
57.00 05700 CT SCAN 58.00 05800 MRI	0. 021606 0. 062483				57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
60. 00 06000 LABORATORY	0. 127996				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 64.00 06400 INTRAVENOUS THERAPY	0.000000				62.00 64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000 1. 168009				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 337345				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0.000000				67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0. 000000 0. 084059				68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 050229				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0. 099260 0. 140723				72.00 73.00
74.00 07400 RENAL DIALYSIS	0. 000000				74.00
75.00 07500 ASC (NON-DI STI NCT PART)	0. 000000				75.00
76. 00 03030 ANGI OCARDI OGRAPHY	0. 000000				76.00
OUTPATI ENT SERVI CE COST CENTERS 88.00 08800 RURAL HEALTH CLI NI C					88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER					89.00
90. 00 09000 CLINIC	0.000000				90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	0. 211081 1. 390688				91.00 92.00
OTHER REIMBURSABLE COST CENTERS	1. 370000				/2.00
94.00 09400 HOME PROGRAM DI ALYSI S	0. 000000				94.00
95. 00 09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000 0. 000000				95.00 96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000				97.00
99. 00 09900 CMHC					99.00
99.10 09910 CORF 100.00 10000 I &R SERVICES-NOT APPRVD PRGM					99.10 100.00
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KI DNEY ACQUI SI TI ON					105.00
106. 00 10600 HEART ACQUISITION 107. 00 10700 LIVER ACQUISITION					106.00 107.00
108. 00 10800 LUNG ACQUI SI TI ON					108.00
109.00 10900 PANCREAS ACQUISITION					109.00
110. 00 11000 INTESTINAL ACQUISITION 111. 00 11100 SLET ACQUISITION					110. 00 111. 00
113. 00 11300 INTEREST EXPENSE					113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)					115.00
116.00 11600 HOSPICE 200.00 Subtotal (see instructions)					116.00 200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0102	Period: From 01/01/2020	Worksheet C	
				To 12/31/2020	Part I Date/Time Pre	pared:
		Ti +1	e XIX	Hospi tal	7/29/2021 3:2 PPS	7 pm
				Costs	<u> </u>	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B, Part I, col.	Adj .		Di sal I owance		
	26)					
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	2, 720, 389		2, 720, 38	9 0	2, 720, 389	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0		2,720,00	0 0	0	1
40. 00 04000 SUBPROVI DER - I PF	0			0 0	0	
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	0			0 0 0 0	0	
ANCI LLARY SERVICE COST CENTERS	0		1	0 0	0	43.00
50. 00 05000 OPERATI NG ROOM	1, 621, 894		1, 621, 89		1, 621, 894	1
51.00 05100 RECOVERY ROOM	0			0 0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	7,940		7,94	-	7, 940	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 254, 716		1, 254, 71	-	1, 254, 716	1
54. 01 05401 ULTRASOUND	139, 507		139, 50		139, 507	
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0 56,062		56, 06	0 0	0 56, 062	
57. 00 05700 CT SCAN	195, 230		195, 23		195, 230	1
58. 00 05800 MRI	129, 790		129, 79	0 0	129, 790	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0 1, 715, 465		1, 715, 46	0 0 5 0	0 1, 715, 465	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		1, 713, 40	0 0	0	1
64. 00 06400 I NTRAVENOUS THERAPY	0			0 0	0	
65. 00 06500 RESPIRATORY THERAPY	621, 758				621, 758	1
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	775, 628		775, 62	8 0 0 0	775, 628 0	1
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	240, 120		240, 12	0 0	240, 120	1
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0 14, 263		14, 26	0 0	0 14, 263	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	16, 054		16, 05		16, 054	1
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 031, 336		1, 031, 33		1, 031, 336	1
74.00 07400 RENAL DIALYSIS 75.00 07500 ASC (NON-DISTINCT PART)	0			0 0 0 0	0	
76. 00 03030 ANGI OCARDI OGRAPHY	0			0 0	0	1
OUTPATIENT SERVICE COST CENTERS					-	1
88.00 08800 RURAL HEALTH CLINIC	0			0 0	0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0			0 0	0	1
91.00 09100 EMERGENCY	2, 477, 762		2, 477, 76	2 0	2, 477, 762	1
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	362, 925		362, 92	5	362, 925	92.00
0THER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S	0		1	0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0			0 0	0	1
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0			0 0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 99. 00 09900 CMHC	0			0 0	0	
99. 10 09910 CORF	0			0	0	1
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0			0		100. 00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0			0	0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0		1	0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0			0		106.00
107.00 10700 LIVER ACQUISITION	0			0		107.00
108. 00 10800 LUNG ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON	0			0		108.00 109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0			0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0			0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.)	0			o	n	114. 00 115. 00
116. 00 11600 HOSPI CE	0			0		116.00
200.00 Subtotal (see instructions)	13, 380, 839				13, 380, 839	1
201.00Less Observation Beds202.00Total (see instructions)	362, 925 13, 017, 914		362, 92 13, 017, 91		362, 925 13, 017, 914	
	1 13,017,714	0	1 15,017,91	'I U	15,017,714	1202.00

	Financial Systems	STARKE MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2020	Worksheet C Part I	
					To 12/31/2020	Date/Time Pre	
				e XIX	Hospi tal	7/29/2021 3:2 PPS	7 pm
			Charges	0 /// //			
	Cost Center Description	Inpati ent	Outpati ent	Total (col. d		TEFRA	
				+ col. 7)	Ratio	Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4, 033, 170		4, 033, 17	0		30.00
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0			0		31.00
40.00	04100 SUBPROVIDER - IRF	0			0		40.00
43.00	04300 NURSERY	0			0		43.00
	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATING ROOM	454, 412	7, 416, 785			0.00000	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0.000000 0 0.000000	0. 000000 0. 000000	
52.00 53.00	05300 ANESTHESI OLOGY	93, 292	1, 626, 376	1, 719, 66		0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	174, 424	3, 555, 324			0. 000000	
54.01	05401 ULTRASOUND	118, 026	1, 708, 864	1, 826, 89		0. 000000	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C		0 0.00000	0.00000	
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	0 1, 038, 346	494, 536 7, 997, 535			0. 000000 0. 000000	
58.00	05800 MRI	90, 737	1, 986, 476			0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C)	0 0.000000	0. 000000	
60.00	06000 LABORATORY	1, 712, 017	11, 690, 520	13, 402, 53		0. 000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0 0.00000	0.00000	
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 339, 345	0 192, 978	532, 32	0 0.000000 3 1.168009	0. 000000 0. 000000	
66. 00	06600 PHYSI CAL THERAPY	220, 057	2, 079, 154			0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	0	2,077,101		0.000000	0. 000000	
68.00	06800 SPEECH PATHOLOGY	0	C		0 0. 000000	0. 000000	68.00
69.00	06900 ELECTROCARDI OLOGY	402, 158	2, 454, 424	2, 856, 58		0. 000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	100 710		0 0.000000	0.00000	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	93, 249	190, 712 161, 737			0. 000000 0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 207, 302	5, 121, 529			0.000000	
74.00	07400 RENAL DIALYSIS	0	C		0 0. 000000	0. 000000	74.00
75.00	07500 ASC (NON-DI STINCT PART)	0	C		0 0. 000000	0.00000	
76.00	03030 ANGI OCARDI OGRAPHY OUTPATI ENT SERVI CE COST CENTERS	0	C		0 0.000000	0. 000000	76.00
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0.000000	0. 000000	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0.000000	0. 000000	
90.00	09000 CLI NI C	0	C		0 0. 000000	0. 000000	
91.00	09100 EMERGENCY	1, 194, 685	10, 543, 768			0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	123, 727	137, 241	260, 96	8 1. 390688	0. 000000	92.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	C		0 0.000000	0. 000000	94.00
	09500 AMBULANCE SERVICES	0	C		0 0. 000000	0. 000000	
	09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0. 000000	0. 000000	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	C		0 0.000000	0.00000	
	09900 CMHC 09910 CORF	0			0		99.00 99.10
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0		100.00
	10100 HOME HEALTH AGENCY	0	C		0		101.00
	SPECIAL PURPOSE COST CENTERS			1			
	10500 KI DNEY ACQUI SI TI ON	0	C		0		105.00
	10600 HEART ACQUISITION 10700 LIVER ACQUISITION	0			0		106.00
	10800 LUNG ACQUISITION	0	C		0		108.00
109.00	10900 PANCREAS ACQUISITION	0	C		0		109.00
	11000 INTESTINAL ACQUISITION	0	C		0		110.00
	11100 I SLET ACQUI SI TI ON	0	C		0		111.00
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF						113.00 114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	ſ		0		115.00
	11600 HOSPI CE	0	C		ō		116.00
200.00	Subtotal (see instructions)	12, 294, 947	57, 357, 959	69, 652, 90	6		200.00
201.00		10 004 017		10 150 00			201.00
202.00	Total (see instructions)	12, 294, 947	57, 357, 959	69, 652, 90	o	I	202.00

COMPUTATION OF RATEO OF CONTS TO GUARDS Provider CDL: 15.0102 Provider CDL: 15	Health Financial Systems	STARKE MEMORIA	L HOSPI TAL	In Lieu	」of Form CMS-2	2552-10
Interview Interview <t< td=""><td></td><td></td><td>Provider CCN: 15-0102</td><td></td><td></td><td></td></t<>			Provider CCN: 15-0102			
TITLE XIX Pospital PPS INPACT ENT BOUTINE SERVICE COST CENTERS 30.00 3000 AULTS & FEDIATICS 30.00 10.00 3000 AULTS & FEDIATICS 30.00 30.00 30.00 10.00 3000 AULTS & FEDIATICS 30.00 30.00 40.00 40.00 10.00 3000 AULTS & FEDIATICS 30.00 40.00 40.00 40.00 10.00 3000 AULTS & FEDIATICS 30.00 40.00 40.00 40.00 10.00 Stote Mark Rev Control 50.00 50.00 50.00 50.00 11.00 GIND RECOVER WORM 0.000000 51.00 50.00 51.00 10.00 Stote Mark Rev Mark 0.000000 51.00 51.00 50.00 11.00 Stote Mark Rev Mark Rev Mark 0.000000 51.00 50.00 51.00 10.00 Stote Mark Rev Mar					Date/Time Pre	pared:
Pairs Pairs 10 00.00 DODD (ALLIS A PULLATION C) 30.00 10.00 DODD (ALLIS A PULLATION C) 31.00 10.00 DODD (ALLIS A PULLATION C) 41.00 11.00 DODD (ALLIS A PULLATION C) 0.000000 11.00 DODD (ALIIS A PULLATION C)			Title XIX	Hospi tal		7 pm
IMPARTENT INCLUME SERVICE CONTICUTIES 30 IDEAD CONTINUES 41 IDEAD CONTINUES 41 IDEAD CONTINUES 41 IDEAD CONTINUES 42 IDEAD CONTINUES 43 IDEAD CONTINUES 43 <t< td=""><td>Cost Center Description</td><td></td><td></td><td></td><td></td><td></td></t<>	Cost Center Description					
30.00 03000 ANLETS & PEDIATRICS 30.00 10.00 01000 SUBPROVIDE - 1FF 41.00 10.00 01000 SUBPROVIDE - 1FF 41.00 10.00 01000 SUBPROVIDE - 1FF 41.00 10.00 0100 SUBPROVIDE - 1FF 41.00 10.00 0100 SUBPROVIDE - 1FF 41.00 10.00 0100 SUBPROVIDE - 1FF 55.00 11.00 05100 SUBPROVIDE - 15F 50.00 11.00 05100 SUBPROVIDE - 15F 50.00 11.00 05100 SUBPROVIDE - 15F 50.00 11.00 0500 SUBPROVID						
31.00 0100 INTERSIVE CARE UNIT 31.00 41.00 0100 SUBROVICE - LEF 41.00 41.00 00000 07100 SUBROVICE - LEF 41.00 41.00 00000 07000 50.00 50.00 51.00 05000 0F5000 50.00 50.00 52.00 05200 0F5100 0.00000 52.00 52.00 05200 0F5000 0.00000 52.00 52.00 05200 0F4000 KARSTESE 10.00Y 0.004017 53.00 05300 KARSTESE 10.00Y 0.00417 53.00 54.00 05400 KARD (KORVER) 0.017468 54.00 55.00 05500 MAID (KORVER) 0.017468 55.00 57.00 05700 CS700 CS700 S5.00 55.00 58.00 05600 MAID (KORVER) 0.017466 55.00 59.00 05600 MAID (KORVER) 0.127996 66.00 60.00 06600 LABORATORY 0.000000 66.00 67.00 05700 CS700						
40.00 ba000 SUBPROVIDER - INF 40.00 41.00 b400 MARCE SERVICE 43.00 43.00 b400 MARCE SERVICES 43.00 51.00 b500 MARCE SERVICES 50.00 51.00 b500 MARCE SERVICES 50.00 53.00 b5300 MARCE MARCE SERVICES 52.00 53.00 b5300 MARCE MARC						1
43.00 ANDI LURGERY 43.00 AND LARY SERVICE COST CENTERS 50.00 50000 OPERATING ROM 0.200054 50.00 51.00 50000 OPERATING ROM 0.200000 52.00 50.00 50.00 52.00 52.00 52.00 52.00 50.00 50.00 50.00 52.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00	40. 00 04000 SUBPROVIDER - IPF					1
ACCILLARY SERVICE COST CENTERS						•
51.00 05100 RECOVERY ROM 0.000000 51.00 52.00 05200 DELVEY ROM & LABOR ROM 0.000100 52.00 53.00 DS400 DELVEY ROM & LABOR ROM 0.000100 53.00 54.00 D5400 DELVEY ROM & LABOR ROM 0.001417 53.00 54.00 D5401 DELVEY ROM 0.075303 54.00 55.00 D5401 DELVEY ROM 0.075403 55.00 55.00 D5401 DELVEY ROM 0.075403 55.00 55.00 D5401 DELVEY ROM 0.075403 55.00 55.00 D5500 CRADA CATHERENZATION 0.062433 55.00 56.00 D5500 CARDA CATHERENZATION 0.0200000 64.00 66.00 D6500 RESPERATONY THEAPY 1.168009 66.00 60.00 D6500 RESPERATONY THEAPY 1.168009 66.00 60.00 D6500 RESPERATONY THEAPY 0.000000 67.00 67.00 D6500 DELVERTRORANY 0.000000						43.00
92.00 95200 DELLIVERY RODU & LABOR RODM 0.000000 52.00 53.00 95300 ARSTHESI DECOY 0.004171 53.00 54.00 95400 RASI LECOY 0.00407 10.00000 54.00 55.00 95500 RADI DECOY 0.004171 0.076363 54.01 55.00 95500 RADI CUCY 11.0340 55.00 55.00 57.00 95500 RADI CUCY 11.0343 55.00 57.00 95700 CT SAM 0.0121400 0.072796 69.00 9500 CRADI CERIA & CATHETERIZATION 0.00000 60.00 69.00 9500 CRADI CARL & CATHETERIZATION 0.00000 60.00 60.00 06000 LABBOATORY 0.000000 65.00 60.00 06000 LABBOATORY 0.000000 65.00 60.00 06000 DECPAILODA & PACKED RED BLODD CELL 0.000000 67.00 60.00 06000 DECPAILODA & THERAPY 0.000000 67.00 60.00 06000 DECPAILODA & THERAPY 0.000000 77.00 70.00 0700 DECPAILODA & THERAPY 0.000000 77.00						1
53.00 05300 AMESTHESI OLOGY 0.004417 53.00 54.00 05400 AMESTHESI OLOGY 0.336408 54.00 55.00 05500 ARD/LOSY-HEXPEUTIC 0.000000 55.00 56.00 05600 RAD/LOSY-HEXPEUTIC 0.000000 55.00 57.00 05700 CT SCAN 0.021606 57.00 58.00 05600 CT SCAN 0.021606 57.00 58.00 05600 ARD/LOSY-HEXPEUTIC 0.000000 59.00 50.00 05600 ARD/LOSY-HEXPEUTIC 0.000000 59.00 50.00 05600 ARD/LOSY-HEXPEUTIC 0.000000 59.00 60.00 05600 ARD/LOSY-HEXPEUTIC 0.000000 66.00 60.00 05600 PESPI RATORY THERPHY 1.168009 66.00 60.00 05600 PESPI RATORY THERPHY 0.337345 66.00 61.00 05600 PESPI RATORY THERPHY 0.000000 67.00 70.00 07000 PESCLET THERPHY 0.000000 67.00 70.00 07000 PESCLET THERPHY 0.000000 77.00 71.00 07000 PESCLET THERPHY						
54. 01 05401 ULTRASONNO 0.76363 55.00 55.00 05500 RADUCSCY-THERAPEUTIC 0.000000 55.00 56.00 05500 RADUCSCY-THERAPEUTIC 0.00000 55.00 57.00 05700 CTSCAN 0.0214606 57.00 58.00 D6800 MRI 0.024483 58.00 58.00 60.00 06600 LABDATORY 0.127996 60.00 66.00 60.00 06600 LABDATORY 0.127996 66.00 67.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00						
55. 00 05500 RADIOLOCY-THERAPEUTIC 0.000000 55.00 65. 00 05600 RADIOLOCY-THERAPEUTIC 0.013333 56.00 65. 00 05700 CT SCAN 0.021606 57.00 65. 00 05600 KR 0.021606 57.00 65. 00 05600 CARDIA C CATHETER JATION 0.024643 58.00 66. 00 06600 KR 0.00000 64.00 66. 00 06600 KR 0.021600 CEL 0.00000 66. 00 06600 KR FIRAPEYP 1.16800P 64.00 66. 00 06600 KR FIRAPEYP 1.16800P 66.00 66. 00 06600 SECCI PATHOLOGY 0.000000 66.00 67.00 06000 SECCI PATHOLOGY 0.000000 70.00 70.00 07000 FLECTEORORDAPHALORAPHY 0.000000 73.00 73.00 07300 LELECTEORORDAPHALORAPHY 0.000000 74.00 70.00 07000 LELECTEORORDAPHALORAPHY 0.000000 74.00 70.00 07000 LELECTEORORDAPHALORAPHY 0.000000 74.00 70.00		1				1
66.00 06400 RADIO ISOTOPE 0.113263 55.00 70.00 67300 CTS 0.0214000 55.00 98.00 06800 CRIAL CATHETERIZATION 0.024400 55.00 90.00 05000 LABORATORY 0.127996 65.00 06.00 06400 LABORATORY 0.127996 65.00 06.00 06400 INTERAPY 0.000000 64.00 06400 INTERAPY 0.337345 66.00 07.00 06600 CEPRIATORY THERAPY 0.337345 66.00 07.00 06600 CEPRIATORY THERAPY 0.000000 67.00 08.00 06600 SPECH PATHOLOGY 0.000000 67.00 09.00 0000 CEPRIATORY 0.000000 67.00 00.00 00000 CEPRIATORY 0.000000 67.00 00.00 00000 CEPRIATORY 0.000000 77.00 00.00000 SPECH PATHOLOGY 0.0147723 77.00 00.000000 CEPRIATORY		1				
B8.00 DSB00 MRI 0.062483 58.00 D59.00 DSM0C CAPDIAC CATHETERIZATION 0.000000 59.00 D50.00 DSM0C LABORATORY 0.127996 60.00 D50.00 DSM0C LABORATORY 0.127996 60.00 D50.00 DSM0C0 E44.00 64.00 64.00 D50.00 DSM0C0 E44.00 66.00 65.00 D50.00 DSM0COULHARDARY THERAPY 0.337345 66.00 D50.00 DSM0COULHARDARY THERAPY 0.034059 67.00 D50.00 DSM0COULHARDARY THERAPY 0.034059 67.00 D50.00 DSM0COULHARDARY THERAPY 0.034059 71.00 D71.00 D7100 LETCROARDARING 0.040050 71.00 D71.00 D71.00 D71.00 D71.00 71.00 D71.00 D71.00 D71.00 D71.00 71.00 D72.00 D72.00 D72.00 D71.00 D71.00 D72.00 D72.00 D72.00 D72.00 <td< td=""><td>56. 00 05600 RADI OI SOTOPE</td><td>0. 113363</td><td></td><td></td><td></td><td>56.00</td></td<>	56. 00 05600 RADI OI SOTOPE	0. 113363				56.00
99.00 05900 ARDIAC CATHETERIZATION 0.000000 60.00 00.00 GOGOU LABORATORY 0.127996 60.00 00.00 06000 HIGLE BLOOD & PACKED RED BLOOD CELL 0.000000 62.00 04.00 06400 ITRATENDY THERAPY 0.000000 65.00 05.00 06500 RESPI RATORY THERAPY 0.337345 66.00 05.00 06700 DCUPATI ONAL THERAPY 0.000000 67.00 05.00 06700 DCUPATI ONAL THERAPY 0.000000 67.00 06.00 06600 ELECTROCARDIOLOGY 0.004000 69.00 0.00 0700 DELECTROCARDIOLOGY 0.084059 69.00 0.10 0700 DELECTROCARDIOLOGY 0.080000 71.00 71.00 0730 DRUGS CHARGED TO PATIENTS 0.140723 73.00 74.00 0730 AASC (NON-DI STINCT PART) 0.000000 75.00 75.00 07300 AASC (NON-DI STINCT PART) 0.000000 75.00 76.00 03300 ASC (NON-DI STINCT PART) 0.000000 76.00 76.00 03300 CHALL PLALY ALLHI CENTER 0		1				1
62 00 06200 MEDIC BLODD & PACKED RED BLOOD CELL 0.000000 62 00 64 00 06400 INTRAVENDUS THERAPY 0.000000 65 00 65 00 06500 PHSTICAL THERAPY 0.37345 66 00 66 00 06700 OC0000 68 00 68 00 66 00 06700 OCUPATI ONAL THERAPY 0.37345 66 00 66 00 06700 OCUPATI ONAL THERAPY 0.000000 68 00 68 00 06800 ELCTEROCARDIOLOGY 0.004059 69 00 70 00 OTODO HEDICEVC CHARGED TO PATI ENTS 0.099260 72 00 71 00 OTADO HEDICAL SUPPLIES CHARGED TO PATI ENTS 0.140723 73 00 74 00 OTADO REAL VISIS 0.000000 75 00 75 00 OTADO RUBAL ENCIST CENTERS 88 00 88 00 88 00 08900 FEDERALY QUALIFIED HALTH CENTER 0.000000 75 00 70 00 OTADO RUBAL ENCLIST CENTERS 0.000000 97 00 90 00 70 00 09700 DESERVLY CE OST CENTERS 90 00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
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QNExt. B., Part Vet of Capit 10 Reduction Reduction Reduction 0001 1.00 2.00 3.00 4.00 5.00 50.00 05000 0FFAATING ROOM 1.621, 694 139, 815 1.420, 70 0 0 50.00 05000 0FFAATING ROOM 0 </th <th></th> <th>Cost Conton Deceniation</th> <th>Tatal Crat</th> <th></th> <th></th> <th>Hospi tal</th> <th>PPS</th> <th></th>		Cost Conton Deceniation	Tatal Crat			Hospi tal	PPS	
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51:00 DSIO0 PECOVERY ROOM A LABOR ROOM 0 0 0 0 52:00 DSIO0 DELIVERY ROOM A LABOR ROOM 7 940 339 7 640 53:00 DSIO0 DESION RATESTHESI OLGCY 7 940 339 7 60 54:01 DSIO0 DARDIOLOCY-THEAREUTIC 0 0 0 0 55:00 DSIOO RADIOLOCY-THEAREUTIC 0 0 0 0 56:00 DSIOO RADIOLOCY-THEAREUTIC 0 0 0 0 56:00 DSIOO RADIOLOCY-THEAREUTIC 0 0 0 0 56:00 DSIOO RADIOLACATHERER LINE 0 0 0 0 56:00 DSIOO RADIOLACATHERER LINE DLODC 1 17.15, 465 47, 577 1, 66, 688 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
52:00 DS200 DELUYERY ROM & LABOR ROM 0 0 0 0 53:00 DS300 RNSTHEST LOGY 7, 940 339 7, 601 1 54:00 DS300 RND IOLOGY - DI AGNOSTI C 1, 254, 716 61, 155 1, 193, 561 0 55:00 DS300 RND IOLOGY - THERAPEUTI C 0 0 0 0 55:00 DS300 RND IOLOGY - THERAPEUTI C 0 0 0 0 56:00 DS300 RND IOLOGY - THERAPEUTI C 0 0 0 0 57:00 DS700 CT SCAN 195, 230 10. 227 1186, 061 0 50:00 DS600 MRIA LABORATORY 1, 715, 465 47, 577 1, 667, 688 0			1, 621, 894	139, 815	1, 482, 0		0	50.00
33.00 05300 AMESTHESI OLGY 7, 940 339 7, 601 0 44.00 05407 ULTRASSOND 1294, 716 61, 155 1, 193, 561 0 54.01 05407 ULTRASSOND 1294, 750 1, 134 138, 373 0 56.00 05500 RADI OLGY-THERAPEUTIC 0 0 0 0 57.00 05700 CRADI OLGY-THERAPEUTIC 0 0 0 0 58.00 05800 MRI 129, 750 19, 729 110, 061 0 0 50.00 65000 ACRI IA CATHETERIZATION 0			0				0	51.00
44.00 65400 RADIOLOCY-DIAGNOSTIC 1.254,716 61,155 1,192,561 0 55.00 RADIOLOCY-DIAGNOSTIC 139,507 0			0				0	52.00
4.01 04:01 ULTRASONND 138, 373 0 4.01 05:00 05:00 05:00 0 0 0 6.00 05:00 05:00 05:00 0 0 0 0 0.00 05:00 CT SCAN 195, 230 0.227 185, 003 0 0 0.00 05:00 CRDI AC CATHETERI ZATI ON 0							0	53.00 54.00
5.00 65500 RAD 0L0CY THERAPEUTIC 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>0</td><td>54.0</td></td<>							0	54.0
6.00 05400 RADIOLSTOPE 56.002 638 55.424 0 0.00 05700 CT SCAN 195.20 10.27 185.003 0 0.00 05900 MRI 129.790 19.729 110.661 0 0.00 05900 ACRIA CCATHETERIZATION 0 0 0 0 0 0 0.00 06000 LABORATORY 1.715.465 47.577 1.667.888 0 0 0.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0.00 06400 PHYSICAL THERAPY 775.628 36.204 739.424 0 0 0 0.00 06400 PHYSICAL THERAPY 775.628 36.204 739.424 0			137, 507				0	55.0
7.00 6700 CT SCAN 195,230 10,227 185,003 0 9.00 69600 CARDIAC CATHETERIZATION 129,790 19,729 110,061 0 9.00 69600 CARDIAC CATHETERIZATION 0			56 062			-	0	56.0
8.00 06800 MRI 129,790 19,729 110,061 0 0.00 06000 LABDRATORY 1,715,465 47,577 1,667,888 0 0.00 6400 INTRAVENUS THERAPY 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>0</td><td>57.00</td></td<>							0	57.00
9.00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							0	58.0
2:00 6200 WHOLE BLOOD & PACKED RED BLOOD CELL 0	9.00 0590	OO CARDI AC CATHETERI ZATI ON	0	(0	59.0
4.00 6400 INTRAVENUUS THERAPY 0 0 0 0 5.00 6500 6500 6500 6500 6500 6500 6500 6500 6500 6500 6500 6500 6500 6600 <	0600 0600	00 LABORATORY	1, 715, 465	47, 57	1, 667, 8	88 0	0	60.0
5.00 06500 RESPI RATORY THERAPY 621.758 16.057 605,701 0 7.00 06600 DVSICAL THERAPY 775,628 36,004 739,424 0 7.00 06600 SPEECH PATHOLOGY 0 0 0 0 0 0.00 06600 SPEECH PATHOLOGY 240,120 8,286 231,834 0			0	(D	0 0	0	62.0
6.00 06400 PHYSICAL THERAPY 775, 628 36, 204 739, 424 0 9.00 06800 SPEECH PATHOLOGY 0 0 0 0 9.00 06900 ELECTROCARDIOLOGY 240, 120 8, 286 231, 834 0 0 0.00 07000 MEDICAL SUPPLIES CHARGED TO PATIENT 14, 263 109 14, 154 0			0	(D	0 0	0	64.0
7.00 60700 OCCUPATIONAL THERAPY 0 0 0 7.00 68700 SPECH PATHOLOGY 0 0 0 0 7.00 68700 FELCTROCARDIOLOGY 240,120 8,286 231,834 0 0 7.00 69700 FELCTROCARDIOLOGY 240,120 8,286 231,834 0 0 7.00 60700 MELCAL SUPPLIES CHARGED TO PATIENT 14,263 109 14,154 0 0 0.00 07300 INPL. DEV. CHARGED TO PATIENTS 1,031,336 20,039 1,011,297 0 0 0.00 07400 RENAL DIALYSIS 0<							0	65.0
8.00 0 66800 SPEECH PATHOLOCY 0 0 0 9.00 066900 ELECTRORAND IOLOGY 240,120 8,286 231,834 0 0 0.00 07000 ELECTRORAND IOLOGY 240,120 8,286 231,834 0 0 0.00 07000 ELECTRORAND IOLOGY 240,120 8,286 231,834 0 0 0.00 70100 MEDI CAL, SUPPLIES CHARGED TO PATIENTS 16,054 95 15,595 0			775, 628	36, 204	1 739, 4		0	66.0
9:00 66900 ELECTROCARDIOLOGY 240,120 8,266 231,834 0 0:00 67000 ELECTROCARDIOLOGY 240,120 8,266 231,834 0 1:00 67100 MEDICAL SUPPLIES CHARGED TO PATIENT 14,263 109 14,154 0 0:00 77200 [NUSC CHARGED TO PATIENTS 16,054 95 15,959 0 0:00 77400 RENAL DIALYSI S 1:00 77300 SURUS CHARGED TO PATIENTS 1,031,336 20,039 1,011,297 0 0:00 0			0	(2	0 0	0	67.0
0.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 14,263 109 14,154 0 0.00 70300 IMPL. DEV. CHARGED TO PATIENTS 1,031,336 20,039 1,011,297 0 0.00 70300 RENAL DI ALYSI S 1,031,336 20,039 1,011,297 0 0.00 70500 ASC (NON-DI STINCT PART) 0 0 0 0 0 0.017601 ANGIOCARDI ORAPHY 0 0 0 0 0 0 0 0.017601 RENL DI ALYSI S 0			0	0.00		0 0	0	68.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 14,263 109 14,154 0 2.00 07200 IMPL. DEV. CHARGED TO PATIENTS 16,054 95 15,959 0 0.00 7300 DRUGS CHARGED TO PATIENTS 1,031,336 20,039 1,011,297 0 0 0.00 7300 GRASC (NON-DISTINCT PART) 0 <td< td=""><td></td><td></td><td>240, 120</td><td>8, 280</td><td>231,8</td><td>34 0</td><td>0</td><td>69.0</td></td<>			240, 120	8, 280	231,8	34 0	0	69.0
2.00 07200 IMPL DEV. CHARGED TO PATIENTS 16,054 95 15,959 0 3.00 07300 DRUGS CHARGED TO PATIENTS 1,031,336 20,039 1,011,297 0 0.00 7400 RENAL DIALYSIS 0 0 0 0 0 0 0.00 7500 ASC (NON-DISTINCT PART) 0 <td< td=""><td></td><td></td><td>14 242</td><td>100</td><td>14 1</td><td>0 0 E4 0</td><td>0</td><td>70. C</td></td<>			14 242	100	14 1	0 0 E4 0	0	70. C
3.00 07300 DRUGS CHARGED TO PATIENTS 1,031,336 20,039 1,011,297 0 4.00 07400 RENAL DIALYSIS 0 0 0 0 5.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0.017400 RENAL DIALYSIS 0 0 0 0 0 0 0.017401 LENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0.01760 FEDERALLY QUALIFIED HEALTH CENTER 0							0	72.0
4.00 07400 RENAL DI ALYSI S 0 0 0 0 5.00 07500 ASC (NON-DI STI NCT PART) 0							0	73.0
5.00 07500 ASC. (NON-DI STINCT PART) 0 <			1,031,330	20, 03	1,011,2		0	74.0
6.00 03030 ANGIOCARDIOGRAPHY 0 0 0 0 0UTPATIENT SERVICE COST CENTERS 0			0	(0	75.0
8. 00 08800 RURAL HEALTH CLINIC 0<	6.00 0303	BO ANGI OCARDI OGRAPHY	0	(0 0	0	76.0
9. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
0.00 09000 CLINIC 0 0 0 0 0.00 09100 EMERGENCY 2,477,762 80,289 2,397,473 0 0 0.00 09000 OBSERVATION BEDS (NON-DISTINCT PART 362,925 21,993 340,932 0 0 0THER REIMBURSABLE COST CENTERS 0			-				0	
1.00 09100 EMERGENCY 2, 477, 762 80, 289 2, 397, 473 0 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 362, 925 21, 993 340, 932 0 0 0THER REI MBURSABLE COST CENTERS 0			0	(2	0 0	0	
0 09200 0BSERVATION BEDS (NON-DISTINCT PART 362,925 21,993 340,932 0 0 OTHER REI MBURSABLE COST CENTERS 0			0	(0 0	0	
OTHER REIMBURSABLE COST CENTERS 4.00 (9400) HOME PROGRAM DIALYSIS 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>0</td><td>91. C</td></td<>							0	91. C
4. 00 09400 HOME PROGRAM DI ALYSI S 0<			302, 923	21, 993	oj 340, 9	52 0	0	92.0
5.00 09500 AMBULANCE SERVICES 0 <td></td> <td></td> <td>0</td> <td>(</td> <td>0</td> <td>0 0</td> <td>0</td> <td>94.0</td>			0	(0	0 0	0	94.0
5.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 7.00 09700 DURABLE MEDICAL EQUIP-SOLD 0			0				0	95.0
0.0 09900 CMHC 0	5.00 0960	DO DURABLE MEDICAL EQUIP-RENTED	0	(0 0	0	96.0
0 09910 CORF 0<	7.00 0970	DO DURABLE MEDICAL EQUIP-SOLD	0	(0 0	0	97.0
00.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 0 0 01.00 HOME HEALTH AGENCY 0			0	(D	0 0	0	99.0
On 100 HOME HEALTH AGENCY O O O SPECIAL PURPOSE COST CENTERS Second Seco			0	(0 0	0	
SPECIAL PURPOSE COST CENTERS 55.00 10500 KIDNEY ACQUISITION 0			0	(2	0 0		100. C
D5.00 10500 KIDNEY ACQUISITION 0 0 0 D6.00 10600 HEART ACQUISITION 0 0 0 0 D6.00 10700 LIVER ACQUISITION 0 0 0 0 0 D7.00 10700 LIVER ACQUISITION 0 0 0 0 0 D8.00 LUNG ACQUISITION 0 0 0 0 0 0 0 D9.00 PANCREAS ACQUISITION 0			0	(ע	0 0	0	101.0
06.00 10600 HEART ACQUISITION 0 0 0 07.00 10700 LIVER ACQUISITION 0 0 0 0 08.00 10800 LUNG ACQUISITION 0 0 0 0 0 09.00 10900 PANCREAS ACQUISITION 0 0 0 0 0 10.00 INTESTINAL ACQUISITION 0 0 0 0 0 0 11.00 INTESTINAL ACQUISITION 0 <td></td> <td></td> <td>0</td> <td>(</td> <td></td> <td>0 0</td> <td>0</td> <td>105.0</td>			0	(0 0	0	105.0
07.00 10700 LIVER ACQUISITION 0 0 0 08.00 10800 LUNG ACQUISITION 0 0 0 0 09.00 10900 PANCREAS ACQUISITION 0 0 0 0 0 09.00 10900 PANCREAS ACQUISITION 0 0 0 0 0 10.00 INTESTINAL ACQUISITION 0			0					105.0
D8.00 LUNG ACQUI SI TI ON 0 0 0 0 D9.00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 10.00 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 11.00 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 11.00 ISLET ACQUI SI TI ON 0 0 0 0 0 0 13.00 INTEREST EXPENSE 0			0					107.0
D9:00 PANCREAS ACQUISITION 0 0 0 0 10:00 INTESTINAL ACQUISITION 0 0 0 0 11:00 INTESTINAL ACQUISITION 0 0 0 0 11:00 INTERST EXPENSE 0 0 0 0 11:00 INTEREST EXPENSE 0 0 0 0 11:00 INTERST EXPENSE 0 0 0 0 11:00 INTERST EXPENSE 0 0 0 0 11:00 INTERST EXPENSE 0 0 0 0 10:00 INTERST EXPENSE			0	(0 0		108.0
10.00 11000 INTESTINAL ACQUISITION 0 0 0 0 11.00 ISLET ACQUISITION 0 0 0 0 0 13.00 INTEREST EXPENSE 0 0 0 0 0 0 14.00 UTILIZATION REVIEW-SNF 0 0 0 0 0 0 15.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 16.00 11600 HOSPICE 0 0 0 0 0 00.00 Subtotal (sum of lines 50 thru 199) 10,660,450 463,686 10,196,764 0 0			0	(0 0		109.0
11.00 1SLET ACQUISITION 0 0 0 0 3.00 11300 INTEREST EXPENSE 0 0 0 0 4.00 11400 UTILIZATION REVIEW-SNF 0 0 0 0 5.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 6.00 11600 HOSPICE 0 0 0 0 0 00.00 Subtotal (sum of lines 50 thru 199) 10,660,450 463,686 10,196,764 0 0			0	(0 0		110.0
13.00 11300 INTEREST EXPENSE 14.00 11400 UTI LI ZATI ON REVIEW-SNF 15.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 16.00 11600 HOSPI CE 0 0 0 0 00.00 Subtotal (sum of lines 50 thru 199) 10,660,450 463,686 10,196,764 0			0	(D	0 0		111. C
5.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0								113. (
6.00 11600 HOSPICE 0 0 0 0 0 10.00 Subtotal (sum of lines 50 thru 199) 10,660,450 463,686 10,196,764 0								114. (
00.00 Subtotal (sum of lines 50 thru 199) 10,660,450 463,686 10,196,764 0	-		0	(ן ע	0 0		115. (
			0	(0 0		116.
								200. (
								201. (202. (

	OF OUTPATIENT SERVICE COST TO CHARGE F FOR MEDICAID ONLY	RATIOS NET OF			Period: From 01/01/2020 To 12/31/2020	Worksheet C Part II Date/Time Prepar 7/29/2021 3:27 p
	Cost Center Description	Cost Net of	Total Charges	e XIX Outpatient	Hospi tal	PPS
	cost center bescription	Capital and	(Worksheet C,		ne	
		Operating Cost				
		Reduction	8)	/ col . 7)	-	
		6.00	7.00	8.00		
ANCI LI	LARY SERVICE COST CENTERS					
	OPERATING ROOM	1, 621, 894	7, 871, 197	0. 20605	54	50
	RECOVERY ROOM	0				51
	DELIVERY ROOM & LABOR ROOM	0	0			52
	ANESTHESI OLOGY	7,940				53
	RADI OLOGY-DI AGNOSTI C	1, 254, 716				54
	ULTRASOUND	139, 507				54
	RADI OLOGY-THERAPEUTI C	0	-			55
	RADI OI SOTOPE	56, 062				56
	CT SCAN	195, 230				57
00 05800		129, 790				58
	CARDIAC CATHETERIZATION					59
	LABORATORY	1, 715, 465				60
	WHOLE BLOOD & PACKED RED BLOOD CELL INTRAVENOUS THERAPY	0				62
	RESPIRATORY THERAPY	621, 758	-			64
	PHYSICAL THERAPY	775, 628				66
	OCCUPATIONAL THERAPY	0				67
	SPEECH PATHOLOGY	0	-			68
	ELECTROCARDI OLOGY	240, 120	-			69
	ELECTROENCEPHALOGRAPHY	240, 120				70
	MEDICAL SUPPLIES CHARGED TO PATIENT	14, 263	-			71
	IMPL. DEV. CHARGED TO PATIENTS	16, 054				72
	DRUGS CHARGED TO PATIENTS	1, 031, 336				73
	RENAL DIALYSIS	1, 031, 330				74
	ASC (NON-DISTINCT PART)	0	-			75
	ANGI OCARDI OGRAPHY	0				76
	TIENT SERVICE COST CENTERS					
	RURAL HEALTH CLINIC	0	0	0.0000	00	88
00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	00	89
	CLINIC	0	0	0. 00000	00	90
00 09100	EMERGENCY	2, 477, 762	11, 738, 453	0. 21108	31	91
00 09200	OBSERVATION BEDS (NON-DISTINCT PART	362, 925	260, 968	1. 39068	38	92
OTHER	REIMBURSABLE COST CENTERS		-			
	HOME PROGRAM DIALYSIS	0				94
	AMBULANCE SERVICES	0	0			95
	DURABLE MEDICAL EQUIP-RENTED	0	0	0.0000		96
	DURABLE MEDICAL EQUIP-SOLD	0	C			97
00 09900		0	(C	0.0000		99
10 09910		0	0			99
	I &R SERVICES-NOT APPRVD PRGM	0		0.00000		100
	HOME HEALTH AGENCY	0	C	0.0000		101
	AL PURPOSE COST CENTERS			0.0000		
	KIDNEY ACQUISITION	0				105
	HEART ACQUISITION	0				106 107
	LUNG ACQUISITION PANCREAS ACQUISITION					108 109
1 1	INTESTINAL ACQUISITION					110
	I SLET ACQUISITION			0.00000		111
	INTEREST EXPENSE			, 0.0000		113
	UTILIZATION REVIEW-SNF					114
	AMBULATORY SURGICAL CENTER (D. P.)	n	C	0. 00000	00	115
. 00 11600		0	-	0.00000		116
), 00	Subtotal (sum of lines 50 thru 199)	10, 660, 450	-			200
1.00	Less Observation Beds	362, 925				200
	1 = = = = = = = = = = = = = = = = = = =					

Health Financial Systems	STARKE MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPI	ITAL COSTS	Provider C		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/29/2021 3:2	pared: 7 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	164, 850	0	164, 85	0 1, 754	93.99	30.00
31.00 INTENSIVE CARE UNIT	0			0 0	0.00	31.00
40. 00 SUBPROVIDER - IPF	0	0		0 0	0.00	40.00
41.00 SUBPROVIDER - IRF	0	0		0 0	0.00	41.00
43.00 NURSERY	0			0 0	0.00	43.00
200.00 Total (lines 30 through 199)	164, 850		164, 85	0 1, 754		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	674	63, 349				30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
40. 00 SUBPROVIDER - IPF	0	0				40.00
41.00 SUBPROVIDER - IRF	0	0				41.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	674	63, 349				200.00

	Financial Systems	STARKE MEMORI					u of Form CMS-2	2552-10
APPORT	ONMENT OF INPATIENT ANCILLARY SERVICE CAPIT,	AL COSTS	Provi	der CO	CN: 15-0102	Period: From 01/01/2020	Worksheet D Part II	
						To 12/31/2020	Date/Time Pre	nared
						10 12/01/2020	7/29/2021 3:2	
				Ti tl e	e XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Ch	arges	Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(from Wks	st. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I,	col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)		2)			
		26)						
		1.00	2.00)	3.00	4.00	5.00	
	ANCI LLARY SERVI CE COST CENTERS	1	1		1			
	05000 OPERATING ROOM	139, 815	7,87	'1, 197			3, 541	50.00
	05100 RECOVERY ROOM	0		0			0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0		0	0.00000		0	52.00
	05300 ANESTHESI OLOGY	339		9, 668				53.00
	05400 RADI OLOGY-DI AGNOSTI C	61, 155		9, 748			1, 303	54.00
	05401 ULTRASOUND	1, 134	1, 82	6, 890	0. 00062	46, 265	29	54.01
	05500 RADI OLOGY-THERAPEUTI C	0		0	0.00000		0	55.00
	05600 RADI OI SOTOPE	638		4, 536			0	56.00
	05700 CT SCAN	10, 227		5, 881			507	57.00
58.00	05800 MRI	19, 729	2,07	7, 213	0.00949	30, 838	293	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		0	0.0000		0	59.00
	06000 LABORATORY	47, 577	13, 40	2, 537	0.00355	50 761, 575	2, 704	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0	0.0000	0 0	0	62.00
64.00	06400 I NTRAVENOUS THERAPY	0		0	0.0000	0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	16, 057	53	2, 323	0. 03016	140, 587	4, 241	65.00
	06600 PHYSI CAL THERAPY	36, 204	2, 29	9, 211	0. 01574	6 125, 310	1, 973	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0		0	0.0000	0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0		0	0.0000	0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	8, 286	2,85	6, 582	0.00290	181, 231	526	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0.00000	0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	109	28	3, 961	0. 00038	34 73, 499	28	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	95	16	1, 737	0. 00058	37 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	20, 039	7,32	8, 831	0. 00273	933, 622	2, 553	73.00
74.00	07400 RENAL DIALYSIS	0		0	0.00000	0 0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0		0	0.00000	0 0	0	75.00
76.00	03030 ANGI OCARDI OGRAPHY	0		0	0.00000	0 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS		_		_			
88.00	08800 RURAL HEALTH CLINIC	0		0	0.0000	0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0.00000	0 0	0	89.00
90.00	09000 CLINIC	0		0	0.00000	0 0	0	90.00
91.00	09100 EMERGENCY	80, 289	11, 73	8, 453	0. 00684	488, 790	3, 343	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	21, 993	26	0, 968	0. 08427	75 73, 240	6, 172	92.00
	OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DI ALYSI S	0		0	0.0000	0 00	0	94.00
95.00	09500 AMBULANCE SERVI CES							95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0.00000	0 0	0	96.00
90.00								
	09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0.0000	0 0	0 27, 222	97.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0102 Period: From 0101/2020 To Worksheet D From 0101/2020 To Worksheet D To Provider CN: 15-0102 Worksheet D From 0101/2020 To Worksheet D To Provider CN: 15-0102 Period: From 0101/2020 To Worksheet D To Provider CN: 15-0102 Period: To Worksheet D To Provider CN: 15-0102 Provi	Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
To 12/31/2020 Date/Time Prepared: 7/29/2013 Date/Time Prepared: 7/29/2013 <thda< td=""><td>APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE</td><td>R PASS THROUGH COST</td><td>S Provider C</td><td></td><td></td><td></td><td></td></thda<>	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COST	S Provider C				
Cost Center Description Nursing School Nursing School Aultied Health Post-Stepdown Adjustments Itile XVIII Hospital PPS 1NPATI ENT ROUTINE_SERVICE COST CENTERS 0							
Interviring School Nursing Scho					10 12/31/2020	Date/lime Pre	pared:
Cost Center Description Nursing School Post-Stepdom Adjustments Al Lied Heal th Cost Al Lied Cost Hall edical Education Al Other Cost 30.00 03000 ADULTS & PEDIATRICS 0				XV/111	Hospi tal		7 pili
Post-Stepdown Adjustments Post-Stepdown Adjustments Cost Education Cost Education Cost 30.00 03000 ADULTS & PEDIATRICS 0	Cost Center Description	Nursing School					
Adj ustments Adj ustments Education Cost 1A 1.00 2A 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 0	COST CENTER Description		Nul Sing School				
Impart ENT ROUTINE SERVICE COST CENTERS 1A 1.00 2A 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 0					1 0031		
INPATIENT ROUTINE SERVICE COST CENTERS 0			1 00		2 00		
30.00 03000 ADULTS & PEDIATRICS 0<	INPATIENT ROUTINE SERVICE COST CENTERS				2.00	0100	
31.00 03100 INTENSIVE CARE UNIT 0		0	0		0 0	0	30.00
40.00 04000 SUBPROVIDER - IPF 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td></td>		0	0		0 0	0	
41.00 04100 SUBPROVIDER - IRF 0<		0	0		0 0		
43.00 04300 NURSERY 0		0	0		0 0	0	
200.00 Total (Lines 30 through 199) 0		0	0		0 0	0	
Cost Center Description Swing-Bed Adjustment (see instructions) Total Costs (sum of cols.) instructions) Total Patient Days Per Diem (col.) 5 + col. 6) Inpatient Program Days 30.00 03000 ADULTS & PEDI ATRICS 0 6.00 7.00 8.00 30.00 03000 ADULTS & PEDI ATRICS 0 0 0.00 6.00 7.00 8.00 31.00 04000 SUBPROVIDER - IPF 0 0 0.00 0.00 0 31.00 40.00 SUBPROVIDER - IPF 0 0 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td></td>		0	0		0 0	0	
Adj uštment Amount (see instructions) Days 5 ÷ col. 6) Program Days 1 hbrough 3, instructions) 1 through 3, instructions) 5 ÷ col. 6) Program Days 1 NPATI ENT ROUTI NE SERVI CE COST CENTERS 0 6.00 7.00 8.00 0.00 03000 ADULTS & PEDIATRI CS 0 0 1,754 0.00 674 30.00 0.00 03100 INTENSI VE CARE UNIT 0 0 0 0.00 0 31.00 40.00 5.00 0 0 0 0.00 0 31.00 40.00 04000 SUBPROVI DER - IPF 0		Swing-Bed	Total Costs	Total Patien	t Per Diem (col.		
Amount (see instructions) 1 through 3, inius col. 4) 0 0 0 0 30.00 03000 ADULTS & PEDIATRICS 0 0 1,754 0.00 674 30.00 31.00 03000 ADULTS & PEDIATRICS 0 0 1,754 0.00 674 30.00 31.00 04000 SUBPROVIDER - IPF 0 0 0 0.00 41.00 43.00 04000 SUBPROVIDER - IRF 0 0 0 0.00 41.00 43.00 04300 NURSERY 0 0 0 0.00 0 43.00 200.00 Total (Lines 30 through 199) Inpati ent Program Program Pass-Through Cost Center Description Inpati ent Program 9.00 30.00 30.00 03000 ADULTS & PEDIATRICS 0 0 30.00 31.00 30.00 03000 ADULTS & PEDIATRICS 0 30.00 31.00 30.00 200.00 Inpati ent Program Program 9.00 31.00 31.00 31.00 <td< td=""><td></td><td></td><td>(sum of cols.</td><td></td><td></td><td></td><td></td></td<>			(sum of cols.				
Instructions) minus col. 4)		Amount (see	through 3,		Í	5 5	
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 1,754 0.00 674 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 0 0.00 0 31.00 40.00 SUBPROVIDER - IPF 0 0 0 0 0 0 0 40.00 SUBPROVIDER - IPF 0		instructions)					
30. 00 03000 ADULTS & PEDIATRICS 0 0 1,754 0.00 674 30. 00 31. 00 03100 INTENSIVE CARE UNIT 0 0 0 0.00 0 31. 00 40. 00 04000 SUBPROVIDER - IPF 0 0 0 0.00 0 40. 00 41. 00 04100 SUBPROVIDER - IRF 0 0 0 0.00 0 41. 00 43. 00 04100 NURSERY 0 0 0 0.00 0 41. 00 200. 00 Total (lines 30 through 199) Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9. 00 674 200. 00 200. 00 Total (NPATIENT ROUTINE SERVICE COST CENTERS 0 30. 00 31. 00 30. 00 03000 ADULTS & PEDIATRICS 0 31. 00 30. 00 03100 INTENSIVE CARE UNIT 0 31. 00 31. 00 03100 INTENSIVE CARE UNIT 0 31. 00 31. 00 03100 INTENSIVE CARE UNIT 0 31. 00 31. 00 040000 SUBPROVIDER - IPF 0 </td <td></td> <td>4.00</td> <td>5.00</td> <td>6.00</td> <td>7.00</td> <td>8.00</td> <td></td>		4.00	5.00	6.00	7.00	8.00	
31.00 03100 INTENSIVE CARE UNIT 0 0 0.00 0 31.00 40.00 04000 SUBPROVI DER - IPF 0 0 0 0.00 0 40.00 41.00 04100 SUBPROVI DER - I RF 0 0 0 0.00 0 41.00 43.00 04300 NURSERY 0 0 0 0.00 0 43.00 200.00 Total (lines 30 through 199) 0 1.754 0 674 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 30.00 30.00 30.00 03000 ADULTS & PEDIATRICS 0 0 31.00 30.00 31.00 03100 INTENSI VE CARE UNIT 0 31.00 31.00 31.00 31.00 31.00 03100 INTENSI VE CARE UNIT 0 0 31.00 31.00 31.00 31.00 03100 INTENSI VE CARE UNIT 0 0 40.00 41.00 41.00 04100 SUBPROVI DER - I IPF 0 43.00 43.00							
40.00 04000 SUBPROVIDER - IPF 0 0 0.00 0 40.00 41.00 04100 SUBPROVIDER - IRF 0 0 0 0.00 0 41.00 43.00 04300 NURSERY 0 0 0 0 0 0 43.00 200.00 Total (lines 30 through 199) 0 1.754 674 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 9.00 9.00 30.00 30.00 30.00 31.00 30.00 31.00 31.00 31.00 31.00 31.00 40.00 43.00 43.00 43.00 04000 SUBPROVIDER - IPF 0 0 43.00 43.00 40.00 04000 SUBPROVIDER - IPF 0 43.00 43.00	30. 00 03000 ADULTS & PEDIATRICS	0	C	1, 75	4 0.00	674	30.00
41.00 04100 SUBPROVIDER - IRF 0 0 0.00 0 41.00 43.00 04300 NURSERY 0 0 0.00 0 43.00 200.00 Total (lines 30 through 199) 0 1,754 674 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 0 30.00 Subprovide Cost Centers 30.00 03000 ADULTS & PEDIATRICS 0 31.00 03100 INTENSIVE CARE UNIT 0 31.00 40.00 04100 SUBPROVIDER - IRF 0 41.00 41.00 04100 SUBPROVIDER - IRF 0 43.00	31.00 03100 INTENSIVE CARE UNIT		C		0 0.00	0	31.00
43.00 04300 NURSERY 0 0 0 0 0 0 43.00 200.00 Total (lines 30 through 199) 0 1,754 674 200.00 674 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 0 30.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 31.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 31.00 31.00 43.00 40.00 04000 SUBPROVIDER - IPF 0 0 43.00 43.00 43.00 04300 NURSERY 0 0 43.00	40. 00 04000 SUBPROVIDER - IPF	0	C		0 0.00	0	40.00
200.00 Total (lines 30 through 199) 0 1,754 674 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	41.00 04100 SUBPROVIDER - IRF	0	C		0 0.00	0	41.00
Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 1NPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 031.00 31.00 03100 INTENSIVE CARE UNIT 0 40.00 SUBPROVIDER - IPF 0 41.00 04300 43.00 04300	43. 00 04300 NURSERY		C		0 0.00	0	43.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS Program Pass-Through Cost (col. 7 x col. 8) 30.00 30.00 30.00 03000 ADULTS & PEDI ATRI CS 0 30.00 31.00 31.00 31.00 31.00 40.00 9.00 40.00 40.00 41.00 41.00 43.00 43.00 60 43.00 </td <td></td> <td></td> <td>0</td> <td>1, 75</td> <td>4</td> <td>674</td> <td>200.00</td>			0	1, 75	4	674	200.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 0 30.00 3000 ADULTS & PEDI ATRI CS 0 30.00 31.00 31.00 40.00 SUBPROVI DER - I PF 0 40.00 41.00 43.00	Cost Center Description						
INPATI ENT ROUTI NE SERVI CE COST CENTERS 0 30.00 30000 ADULTS & PEDI ATRI CS 0 30.00 31.00 31.00 VINTENSI VE CARE UNI T 0 31.00 40.00 SUBPROVI DER - I PF 0 40.00 41.00 41.00 43.00 VINTENSI VE CARE UNI T 0 43.00							
col.8) 9.00 1NPATI ENT ROUTI NE SERVICE COST CENTERS 9.00 30.00 03000 ADULTS & PEDIATRICS 0 31.00 03100 INTENSI VE CARE UNIT 0 40.00 04000 SUBPROVIDER - IPF 0 41.00 04100 SUBPROVIDER - IRF 0 43.00 04300 NURSERY 0							
9.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 31.00 03100 INTENSIVE CARE UNIT 0 31.00 40.00 SUBPROVIDER - IPF 0 40.00 41.00 O4300 NURSERY 0 43.00							
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							
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		9.00					
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							0.00
40. 00 04000 SUBPROVI DER - I PF 0 40. 00 41. 00 04100 SUBPROVI DER - I RF 0 41. 00 43. 00 04300 NURSERY 0 43. 00		0					
41.00 04100 SUBPROVI DER - I RF 0 41.00 43.00 04300 NURSERY 0 43.00		0					
43. 00 04300 NURSERY 0 43. 00		0					
		0					
200.00 10tal (lines 30 through 199) 0 200.00		0					
	200.00 lotal (lines 30 through 199)	0					200.00

Heal th	Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C	CN: 15-0102	Peri od:	Worksheet D	
THROUG	H COSTS				From 01/01/2020		
					To 12/31/2020		pared:
				XVIII	Hospi tal	7/29/2021 3:2 PPS	<u>/ piii</u>
	Cost Center Description	Non Dhycician			Allied Health		
	cost center bescription		Post-Stepdown	Nul Sing Schoo	Post-Stepdown		
		Cost	Adjustments		Adj ustments		
		1.00	2A	2.00	3A	3.00	
	ANCI LLARY SERVI CE COST CENTERS	1.00	24	2.00	57	5.00	
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0		52.00
52.00	05300 ANESTHESI OLOGY	0			0 0	-	52.00
		0	0			-	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
54.01	05401 ULTRASOUND	0	0		0 0	-	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0		0 0	-	56.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MRI	0	0		0 0	-	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00	06000 LABORATORY	0	0		0 0	-	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0		0 0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
76.00	03030 ANGI OCARDI OGRAPHY	0	0		0 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS			•			1
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
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
91.00	09100 EMERGENCY	0	0		0 0	l o	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				-1	-	
94.00	09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95.00	09500 AMBULANCE SERVICES	U U				l	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	-	
200.00		0			0 0		200.00
200.00		0	0	I	- -	0	1200.00

Health Financial Systems		STARKE MEMORI				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIEN THROUGH COSTS	NT/OUTPATIENT ANCILLARY SE	ERVICE OTHER PASS	S Provider C		Period: From 01/01/2020	Worksheet D Part IV	
THROUGH COSTS					To 12/31/2020	Date/Time Pre	
			Ti tl c	XVIII	Hospi tal	7/29/2021 3:2 PPS	7 pm
Cost Center I)escription	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
		Education Cost	•	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
			í í	and 4)	· ·	(see	
				, í		instructions)	
		4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE					-		
50.00 05000 OPERATING R00		0			0 7, 871, 197	0. 000000	
51.00 05100 RECOVERY ROOM		0			0 0	0.00000	•
52.00 05200 DELIVERY ROOM		0	0		0 0	0. 000000	•
53.00 05300 ANESTHESI OL00		0	0		0 1, 719, 668	0. 000000	
54.00 05400 RADI OLOGY-DI	AGNOSTI C	0	0		0 3, 729, 748	0.00000	•
54.01 05401 ULTRASOUND		0	0		0 1, 826, 890	0.00000	
55.00 05500 RADI OLOGY-THI	ERAPEUTI C	0	0		0 0	0. 000000	
56. 00 05600 RADI 0I SOTOPE		0	0		0 494, 536	0. 000000	56.00
57.00 05700 CT SCAN		0	0		0 9, 035, 881	0. 000000	57.00
58.00 05800 MRI		0	0		0 2, 077, 213	0. 000000	•
59.00 05900 CARDI AC CATHI	ETERI ZATI ON	0	0		0 0	0. 000000	•
60. 00 06000 LABORATORY		0	0		0 13, 402, 537	0.00000	•
	& PACKED RED BLOOD CELL	0	0		0 0	0.00000	•
64.00 06400 I NTRAVENOUS		0	0		0 0	0.000000	•
65. 00 06500 RESPI RATORY		0	0		0 532, 323	0.00000	•
66. 00 06600 PHYSI CAL THEI		0	0		0 2, 299, 211	0.00000	•
67.00 06700 0CCUPATI ONAL		0	0		0 0	0.00000	•
68.00 06800 SPEECH PATHO		0	0		0 0	0.00000	
69.00 06900 ELECTROCARDI		0	0		0 2, 856, 582	0.00000	
70.00 07000 ELECTROENCEP		0	0		0 0	0.000000	
	LIES CHARGED TO PATIENT	0	0		0 283, 961	0.000000	•
72.00 07200 I MPL. DEV. CH		0	0		0 161, 737	0.000000	
73.00 07300 DRUGS CHARGEI		0	0		0 7, 328, 831 0 0	0.000000	•
74.00 07400 RENAL DIALYS		0			0 0	0.000000 0.000000	•
76. 00 03030 ANGI OCARDI OGI		0			0 0	0.000000	•
OUTPATIENT SERVICE		0	0		0 0	0.00000	76.00
88.00 08800 RURAL HEALTH		0	0		0 0	0. 000000	88.00
	ALIFIED HEALTH CENTER	0			0 0	0.000000	
90. 00 09000 CLINIC	SETTED HEALTH GENTER	0			0 0	0.000000	•
91. 00 09100 EMERGENCY		0			0 11, 738, 453	0.000000	•
	BEDS (NON-DISTINCT PART	0	-		0 260, 968	0.000000	•
OTHER REI MBURSABLE		0	0	1	200, 900	0.000000	/2.00
94.00 09400 HOME PROGRAM		0	0		0 0	0.00000	94.00
95. 00 09500 AMBULANCE SEI			ĺ			0.00000	95.00
96.00 09600 DURABLE MEDI		0	0		0 0	0.000000	•
97.00 09700 DURABLE MEDI		0			0 0	0. 000000	•

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI THROUGH COSTS	ERVICE OTHER PASS	Provider CC	CN: 15-0102	Peri od:	Worksheet D	
				From 01/01/2020 To 12/31/2020	Part IV Date/Time Prep 7/29/2021 3:22	
		Title	XVIII	Hospi tal	PPS	7 piii
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpatient	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.	J	Costs (col.		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0.000000	199, 360		0 1, 885, 724	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	o	52.00
53. 00 05300 ANESTHESI OLOGY	0.000000	47, 858		0 403, 644	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	79, 443		0 673, 454	0	54.00
54. 01 05401 ULTRASOUND	0. 000000	46, 265		0 313, 504	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	10, 200		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0, 000000	0		0 270, 324	0	56.00
57. 00 05700 CT SCAN	0.000000	447, 447		0 2, 418, 343	0	57.00
58. 00 05800 MRI	0.000000	30, 838		0 2, 410, 343	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000	30, 838		0 540, 788	0	59.00
60. 00 06000 LABORATORY	0.000000	741 575			0	60.00
	0.000000	761, 575		., ,	0	62.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0		-	-	
64. 00 06400 I NTRAVENOUS THERAPY	0.00000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0.00000	140, 587		0 55, 642	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.00000	125, 310		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	181, 231		0 883, 702	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	73, 499		0 68, 195	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 71, 295	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	933, 622		0 1, 656, 628	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0		0 0	0	75.00
76. 00 03030 ANGI OCARDI OGRAPHY	0.00000	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0.000000	0		0 0	0	88.00
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
91. 00 09100 EMERGENCY	0. 000000	488, 790		0 2, 383, 870	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	73, 240		0 98, 533	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S	0.000000	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES						95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0		0 0	0	96.00
		-		-	-	
97. 00 09700 DURABLE MEDICAL EQUI P-SOLD	0. 000000	0		0 0	0	97.00

Health Financial Systems	STARKE MEMORI			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2020	Worksheet D Part V	
				To 12/31/2020	Date/Time Pre 7/29/2021 3:2	epared: 7 nm
		Title	e XVIII	Hospi tal	PPS	., b
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins (see inst.)	Ded. & Coins. (see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		2.00	0100		0.00	
50. 00 05000 OPERATI NG ROOM	0. 206054	1, 885, 724		0 0	388, 561	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0)	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 004617	403, 644		0 0	1, 864	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 336408	673, 454		0 0	226, 555	54.00
54. 01 05401 ULTRASOUND	0. 076363			0 0	23, 940	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0 0		0 0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 113363		1	0 0	30, 645	
57.00 05700 CT SCAN	0. 021606			0 0	52, 251	
58.00 05800 MRI	0. 062483			0 0	34, 165	
59.00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			0 0	0	
60. 00 06000 LABORATORY	0. 127996		2,66		206, 083	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			0 0	0	
64. 00 06400 I NTRAVENOUS THERAPY	0.00000			0 0	0 64, 990	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	1. 168009 0. 337345		1	0 0 0 0	04, 990	
67. 00 06700 OCCUPATIONAL THERAPY	0. 000000			0 0	0	
68. 00 06800 SPEECH PATHOLOGY	0. 000000			0 0	0	•
69. 00 06900 ELECTROCARDI OLOGY	0. 084059			0 0	74, 283	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			0 0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 050229			0 0	3, 425	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.099260			0 0	7, 077	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 140723			0 32, 356	233, 126	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0)	0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
76. 00 03030 ANGI OCARDI OGRAPHY	0. 000000	0 0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS		-				
88.00 08800 RURAL HEALTH CLINIC						88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
90. 00 09000 CLINIC	0. 000000			0 0	0	
91. 00 09100 EMERGENCY	0. 211081				503, 190	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	1. 390688	98, 533		0 0	137, 029	92.00
0THER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000	1	1	0 0		94.00
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0.000000			0 0		94.00
95. 00 09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000			0 0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0.000000				0	
200.00 Subtotal (see instructions)	5.000000	13, 339, 723	2, 93	0	1, 987, 184	
201.00 Less PBP Clinic Lab. Services-Program		10,007,720	2,75	0 0	1, 707, 104	201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		13, 339, 723	2, 93	8 32, 356	1, 987, 184	202.00

APPORTI ONMEN	IT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	- CCN: 15-0102	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pre 7/29/2021 3:2	epared 27 pm
			Ti	tle XVIII	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimburse	d			
		Servi ces	Services No	ot			
		Subject To	Subject To	o			
		Ded. & Coins.	Ded. & Coin	IS.			
		(see inst.)	(see inst.)			
		6.00	7.00				
	LARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0		0			50. C
51.00 05100	RECOVERY ROOM	0		0			51. C
52.00 05200	DELIVERY ROOM & LABOR ROOM	0		0			52. C
	ANESTHESI OLOGY	0		0			53. C
54.00 05400	RADI OLOGY-DI AGNOSTI C	0		0			54. C
	ULTRASOUND	0		o			54. C
	RADI OLOGY-THERAPEUTI C	0		0			55. C
	RADI OI SOTOPE	0		0			56.0
	CT SCAN	0		0			57.0
8.00 05800		0		0			58.0
	CARDI AC CATHETERI ZATI ON	0		0			59.0
	LABORATORY	341		0			60.0
1 1				0			
	WHOLE BLOOD & PACKED RED BLOOD CELL	0					62.0
	INTRAVENOUS THERAPY	0		0			64.0
	RESPI RATORY THERAPY	0		0			65.0
	PHYSI CAL THERAPY	0		0			66. (
	OCCUPATIONAL THERAPY	0		0			67.0
	SPEECH PATHOLOGY	0		0			68.0
	ELECTROCARDI OLOGY	0		0			69.0
	ELECTROENCEPHALOGRAPHY	0		0			70.0
	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0			71. (
	IMPL. DEV. CHARGED TO PATIENTS	0		0			72.0
	DRUGS CHARGED TO PATIENTS	0	4, 5	553			73.0
	RENAL DIALYSIS	0		0			74.0
	ASC (NON-DISTINCT PART)	0		0			75.0
	ANGI OCARDI OGRAPHY	0		0			76. (
	TIENT SERVICE COST CENTERS						
	RURAL HEALTH CLINIC						88.0
	FEDERALLY QUALIFIED HEALTH CENTER						89.0
0.00 09000	CLINIC	0		0			90.0
91.00 09100	EMERGENCY	57		0			91.0
	OBSERVATION BEDS (NON-DISTINCT PART	0		0			92.0
	REIMBURSABLE COST CENTERS						
	HOME PROGRAM DI ALYSI S	0		0			94.0
	AMBULANCE SERVICES	0					95.0
	DURABLE MEDICAL EQUIP-RENTED	0		o			96.0
	DURABLE MEDICAL EQUIP-SOLD	0		0			97.
00.00	Subtotal (see instructions)	398		553			200.
01.00	Less PBP Clinic Lab. Services-Program	0	4, 5				200.
01.00	Only Charges						201.0
	Net Charges (line 200 - line 201)	398		553			202.

Health Financial Systems	STARKE MEMORI.			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CA	PITAL COSTS	Provider C	 -	Period: From 01/01/2020 Fo 12/31/2020		pared: 7 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	164, 850	0	164, 850	0 1, 754	93.99	30.00
31.00 INTENSIVE CARE UNIT	0			0 0	0.00	31.00
40. 00 SUBPROVIDER - IPF	0	0	(0 0	0.00	40.00
41.00 SUBPROVIDER - IRF	0	0	(0 0	0.00	41.00
43.00 NURSERY	0			0 0	0.00	43.00
200.00 Total (lines 30 through 199)	164, 850		164, 850	0 1, 754		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	47	4, 418				30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
40. 00 SUBPROVIDER - IPF	0	0				40.00
41.00 SUBPROVIDER - IRF	0	0				41.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	47	4, 418				200.00

Health Financial Systems	STARKE MEMORI				In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provi de	er C(CN: 15-0102	Period: From 01/01/2020 To 12/31/2020		pared: 7 pm
				e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal			Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst			Program	(column 3 x	
	(from Wkst. B,	Part I, c	ol.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)		2)			
	26)						
	1.00	2.00		3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	400.045	7.074	407	0.0177	45.000	015	50.00
50. 00 05000 OPERATING ROOM	139, 815						50.00
51.00 O5100 RECOVERY ROOM	0		0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0	0.0000		-	52.00
53.00 05300 ANESTHESI OLOGY	339						53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	61, 155						54.00
54.01 05401 ULTRASOUND	1, 134		890				54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0	0.0000		-	55.00
56. 00 05600 RADI 0I SOTOPE	638		536			-	56.00
57.00 05700 CT SCAN	10, 227			0.00113			57.00
58. 00 05800 MRI	19, 729	2,077	213				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0	0.0000		0	59.00
60. 00 06000 LABORATORY	47, 577	13, 402	537			243	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0	0.0000		0	62.00
64.00 06400 INTRAVENOUS THERAPY	0		0	0.0000		0	64.00
65. 00 06500 RESPI RATORY THERAPY	16, 057	532	323	0. 03016	54 13, 616	411	65.00
66. 00 06600 PHYSI CAL THERAPY	36, 204	2, 299	211	0. 01574	46 5, 553	87	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0		0	0.0000	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0		0	0.0000	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	8, 286	2, 856	582	0.00290	01 14, 102	41	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0		0	0.0000	0 00	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	109	283	961	0. 00038	34 13, 458	5	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	95	161	737	0. 00058	37 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	20, 039	7, 328	831	0. 00273	34 132, 929	363	73.00
74. 00 07400 RENAL DI ALYSI S	0		0	0.0000	0 00	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0		0	0.00000	0 00	0	75.00
76. 00 03030 ANGI OCARDI OGRAPHY	0		0	0.0000	0 00	0	76.00
OUTPATIENT SERVICE COST CENTERS				•			
88.00 08800 RURAL HEALTH CLINIC	0		0	0.0000	0 00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0.0000	0 00	0	89.00
90. 00 09000 CLINIC	0		0	0.0000	0 00	0	90.00
91. 00 09100 EMERGENCY	80, 289	11, 738	453	0.00684	40 57, 734	395	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	21, 993		968				92.00
OTHER REIMBURSABLE COST CENTERS							1
94. 00 09400 HOME PROGRAM DI ALYSI S	0		0	0.0000	0 00	0	94.00
95. 00 09500 AMBULANCE SERVICES			-				95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0		0	0.0000	0 00	0	96.00
97. 00 09700 DURABLE MEDICAL EQUI P-SOLD	0		0	0.00000		0	97.00
200.00 Total (lines 50 through 199)	463, 686	65, 619	736		422, 915	2, 781	200.00
			-				

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COST	S Provider C		Peri od:	Worksheet D	
				From 01/01/2020	Part III	
				To 12/31/2020	Date/Time Pre 7/29/2021 3:2	pared: 7 nm
		Titl	e XIX	Hospi tal	PPS	<i>i</i> piii
Cost Center Description	Nursi ng School			Allied Health	All Other	
	Post-Stepdown	J	Post-Stepdowr		Medi cal	
	Adjustments		Adjustments		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	
31.00 03100 INTENSIVE CARE UNIT	0	C		0 0	0	
40. 00 04000 SUBPROVIDER - IPF	0	0		0 0	0	
41. 00 04100 SUBPROVIDER – IRF	0	C		0 0	0	
43. 00 04300 NURSERY	0	C		0 0	0	
200.00 Total (lines 30 through 199)	0	0		0 0		200.00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adj ustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions) 4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	0.00	7.00	8.00	
30. 00 03000 ADULTS & PEDI ATRICS	0	0	1, 75	4 0.00	47	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	1,75	0.00	47	
40. 00 04000 SUBPROVI DER - I PF	0	0		0.00	0	•
41. 00 04100 SUBPROVIDER - IRF	0	0		0 0.00	0	
43. 00 04300 NURSERY	0	0		0 0.00	0	
200.00 Total (lines 30 through 199)		0	1, 75			200.00
Cost Center Description	I npati ent		1,70	•		200.00
	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
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	B Provider C	CN: 15-0102	Period:	Worksheet D	
THROUGH COSTS				From 01/01/2020	Part IV	norod.
				To 12/31/2020	Date/Time Pre 7/29/2021 3:2	pareu: 7 nm
		Ti †I	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician			I Allied Health		
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS					-	
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 01 05401 ULTRASOUND	0	0		0 0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58. 00 05800 MRI	0	0	1	0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	1	0 0	0	59.00
60. 00 06000 LABORATORY	0	0	1	0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0	1	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	1	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	1	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
76. 00 03030 ANGI OCARDI OGRAPHY	0	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90. 00 09000 CLI NI C	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS	1			1		
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	
95.00 09500 AMBULANCE SERVICES						95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
200.00 Total (lines 50 through 199)	0	0		0 0	-	200.00

Heal th Financial		STARKE MEMORI		01 45 0400		eu of Form CMS-2	2552-10
THROUGH COSTS	INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C		Period: From 01/01/2020	Worksheet D Part IV	
THROUGH CUSIS					To 12/31/2020	Date/Time Pre	pared:
						7/29/2021 3:2	7 pm
				e XIX	Hospi tal	PPS	
Cost	Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medical	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
		4.00	5.00	6.00	7.00	instructions) 8.00	
	SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
50. 00 05000 OPER		0	0		0 7, 871, 197	0, 000000	50.00
51.00 05100 RECO		0	-		0 , 0, 1, 1, 7	0.000000	
	VERY ROOM & LABOR ROOM	0	0		0 0	0.000000	
53.00 05300 ANES		0			0 1, 719, 668	0. 000000	
	OLOGY-DI AGNOSTI C	0	0		0 3, 729, 748	0. 000000	
54.01 05401 ULTR		0	0		0 1, 826, 890		
	OLOGY-THERAPEUTI C	0	0		0 0	0. 000000	
56.00 05600 RADI		0			0 494, 536		
57.00 05700 CT S		0	0		0 9, 035, 881	0. 000000	
58.00 05800 MRI		0	0		0 2,077,213	0. 000000	
	I AC CATHETERI ZATI ON	0	0		0 2,077,210	0. 000000	
60.00 06000 LABO		0	0		0 13, 402, 537	0. 000000	
	E BLOOD & PACKED RED BLOOD CELL	0	0		0 10, 102, 007	0. 000000	
	AVENOUS THERAPY	0	0		0 0	0. 000000	
	I RATORY THERAPY	0	0		532, 323	0. 000000	
	I CAL THERAPY	0	0		0 2, 299, 211	0.000000	
67.00 06700 OCCU	PATIONAL THERAPY	0	0		0 0	0.000000	67.00
	CH PATHOLOGY	0	0		o o	0.000000	68.00
69.00 06900 ELEC	TROCARDI OLOGY	0	0		0 2, 856, 582	0. 000000	69.00
70.00 07000 ELEC	TROENCEPHALOGRAPHY	0	0		0 0	0. 000000	70.00
71.00 07100 MEDI	CAL SUPPLIES CHARGED TO PATIENT	0	0)	0 283, 961	0.000000	71.00
72.00 07200 I MPL	. DEV. CHARGED TO PATIENTS	0	0)	0 161, 737	0. 000000	72.00
73.00 07300 DRUG	S CHARGED TO PATIENTS	0	0)	0 7, 328, 831	0. 000000	73.00
74.00 07400 RENA	L DIALYSIS	0	0		0 0	0. 000000	74.00
75.00 07500 ASC	(NON-DISTINCT PART)	0	0		0 0	0.000000	75.00
	OCARDI OGRAPHY	0	0		0 0	0.000000	76.00
	SERVICE COST CENTERS		-			-	
	L HEALTH CLINIC	0			0 0		
	RALLY QUALIFIED HEALTH CENTER	0	0		0 0	0. 000000	
90.00 09000 CLIN		0	0		0 0	0. 000000	
91.00 09100 EMER		0	0		0 11, 738, 453	0. 000000	91.00
	RVATION BEDS (NON-DISTINCT PART	0	0		0 260, 968	0.000000	92.00
	BURSABLE COST CENTERS		1	1		1	-
	PROGRAM DI ALYSI S	0	0		0 0	0. 000000	
	LANCE SERVICES						95.00
	BLE MEDICAL EQUIP-RENTED	0	0		0 0	0. 000000	
	BLE MEDICAL EQUIP-SOLD	0	0		0 0	0. 000000	
200.00 Tota	l (lines 50 through 199)	0	0	1	0 65, 619, 736		200.00

Health Financial Systems	STARKE MEMORIA				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS	Provider CO	CN: 15-0102	Period: From 01/01/2020 To 12/31/2020		nared
				10 12/31/2020	7/29/2021 3:2	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	h Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	TT		1			
50.00 05000 OPERATING ROOM	0. 000000	45, 893		0 0		50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	9, 264		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	3, 232		0 0	0	54.00
54. 01 05401 ULTRASOUND	0. 000000	1, 929		0 0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	39, 138		0 0	0	57.00
58. 00 05800 MRI	0. 000000	15, 419		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	68, 572		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	13, 616		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	5, 553		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0, 000000	14, 102		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	13, 458		0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	10, 100		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	132, 929		0 0	0	73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000	102, 727		0 0	0	74.00
75. 00 07500 ASC (NON-DI STI NCT PART)	0. 000000	0		0 0	0	75.00
76. 00 03030 ANGI OCARDI OGRAPHY	0. 000000	0		0 0		76.00
OUTPATIENT SERVICE COST CENTERS	0.000000	0	I	0 0	0	/0.00
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	-	89.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	57, 734		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	2,076		0 0		91.00
OTHER REIMBURSABLE COST CENTERS	0.000000	2,070	1	<u> </u>	0	12.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0.000000	0		0	0	95.00
95. 00 09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	95.00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0		97.00
200.00 Total (lines 50 through 199)	0.000000	422, 915		0 0		200.00
	1 1	422, 713	I	- Ч	0	200.00

	ncial Systems	STARKE MEMORI				u of Form CMS-	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C	CN: 15-0102	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pre	pared:
						7/29/2021 3:2	7 pm
				e XIX	Hospi tal	PPS	
	Cost Conton Description	Cost to Charge	DDC Doimhurood	Charges Cost	Cost	Costs PPS Services	
	Cost Center Description	Ratio From	PPS Reimbursed Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Servi ces Not	(See Thist.)	
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins	2		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCI L	LLARY SERVICE COST CENTERS						
50.00 05000	O OPERATING ROOM	0. 206054	0		0 114, 425	0	50.00
51.00 05100	O RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00 05200	O DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53.00 05300	O ANESTHESI OLOGY	0. 004617	0		0 23, 162	0	53.00
	0 RADI OLOGY-DI AGNOSTI C	0. 336408	0		0 83, 869	0	54.00
	1 ULTRASOUND	0. 076363	0		0 59, 527	0	54.01
	0 RADI OLOGY-THERAPEUTI C	0. 000000			0 0	0	
	0 RADI OI SOTOPE	0. 113363			0 0	0	
	O CT SCAN	0. 021606			0 295, 609	0	57.00
58.00 05800		0. 062483			0 11, 861	0	
	O CARDI AC CATHETERI ZATI ON	0. 000000			0 0	0	
	0 LABORATORY	0. 127996			0 431, 939	0	
	O WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			0 0	0	
	O I NTRAVENOUS THERAPY	0.00000			0 0	0	
	0 RESPI RATORY THERAPY	1. 168009			0 5, 930	0	
	O PHYSI CAL THERAPY	0. 337345			0 10, 356	0	
	O OCCUPATI ONAL THERAPY	0. 000000			0 0	0	
	O SPEECH PATHOLOGY	0. 000000			0 0	0	1
	O ELECTROCARDI OLOGY	0. 084059			0 41, 409	0	
	O ELECTROENCEPHALOGRAPHY	0. 000000			0 0 0 581	0	
	O MEDICAL SUPPLIES CHARGED TO PATIENT	0. 050229				0	
	O DRUGS CHARGED TO PATIENTS	0. 099280			0 4, 617 0 98, 931	0	
	O RENAL DI ALYSI S	0. 140723			0 90, 931	0	
	O ASC (NON-DI STI NCT PART)	0.000000			0 0	0	
	0 ANGI OCARDI OGRAPHY	0. 000000			0 0	0	
	ATIENT SERVICE COST CENTERS	0.00000	0	1	0 0	0	/0.00
	O RURAL HEALTH CLINIC			1			88.00
	O FEDERALLY QUALIFIED HEALTH CENTER						89.00
	O CLINIC	0. 000000	0		0 0	0	
	0 EMERGENCY	0. 211081	0		0 565, 202	0	
	O OBSERVATION BEDS (NON-DISTINCT PART	1. 390688	0		0 4, 590	0	
	R REIMBURSABLE COST CENTERS						
	O HOME PROGRAM DI ALYSI S	0. 000000			0 0		94.00
	O AMBULANCE SERVI CES	0.00000			0		95.00
	O DURABLE MEDI CAL EQUI P-RENTED	0.00000			0 0	0	
97.00 09700	O DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	97.00
200.00	Subtotal (see instructions)		0		0 1, 752, 008	0	200.00
200.00							
200.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Less PBP Clinic Lab. Services-Program Only Charges Net Charges (line 200 - line 201)		0		0 0 0 1, 752, 008		201.00 202.00

APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 15-0102	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pre 7/29/2021 3:2	epared: 27 pm
			Ti	tle XIX	Hospi tal	PPS	- p
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services No				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins				
		(see inst.)	(see inst.)				
		6.00	7.00				
	LLARY SERVICE COST CENTERS	-					1
	O OPERATING ROOM	0	23, 5				50.0
	O RECOVERY ROOM	0		0			51.0
	O DELIVERY ROOM & LABOR ROOM	0		0			52.0
	O ANESTHESI OLOGY	0		07			53.0
	0 RADI OLOGY-DI AGNOSTI C	0	28, 2				54.0
	1 ULTRASOUND	0	4, 5				54.0
	0 RADI OLOGY-THERAPEUTI C	0		0			55.0
	0 RADI 0I SOTOPE	0		0			56.0
	O CT SCAN	0	6, 3				57.0
58.00 0580		0	7	41			58.0
	O CARDI AC CATHETERI ZATI ON	0		0			59.0
	0 LABORATORY	0	55, 2				60.0
	O WHOLE BLOOD & PACKED RED BLOOD CELL	0		0			62.0
	O I NTRAVENOUS THERAPY	0		0			64.0
	0 RESPI RATORY THERAPY	0	6, 9				65.0
	0 PHYSI CAL THERAPY	0	3, 4				66.0
	0 OCCUPATIONAL THERAPY	0		0			67.0
	O SPEECH PATHOLOGY	0		0			68.0
		0	3, 4				69.0
	O ELECTROENCEPHALOGRAPHY	0		0			70.0
	O MEDI CAL SUPPLIES CHARGED TO PATIENT	0		29			71.0
	O IMPL. DEV. CHARGED TO PATIENTS	0		58			72.0
	O DRUGS CHARGED TO PATIENTS	0	13, 9				73.0
	O RENAL DI ALYSI S	0		0			74.0
	O ASC (NON-DI STI NCT PART)	0		0			75.0
	O ANGI OCARDI OGRAPHY ATI ENT SERVI CE COST CENTERS	0		0			76.0
	O RURAL HEALTH CLINIC						88.0
	O FEDERALLY QUALIFIED HEALTH CENTER						89.0
	O CLINIC	0		0			90.0
		0	110.0	-			
	O EMERGENCY	0	119, 3				91.0
	O OBSERVATION BEDS (NON-DISTINCT PART	0	6, 3	03			92.0
	R REIMBURSABLE COST CENTERS	0		0			94.0
	O AMBULANCE SERVICES	0					94.0
	O DURABLE MEDICAL EQUIP-RENTED	0		0			95.0
		0		0			
	O DURABLE MEDICAL EQUIP-SOLD	0	272 0	55			97.0
200.00 201.00	Subtotal (see instructions)	0	272, 8	55			200. 0 201. 0
01.00	Less PBP Clinic Lab. Services-Program Only Charges	0					201.0
	Net Charges (line 200 - line 201)	1					1

	Financial Systems STARKE M ATLON OF INPATIENT OPERATING COST	MEMORIAL HOSPITAL Provider CCN: 15-0102	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2020 To 12/31/2020	Date/Time Prep 7/29/2021 3:2	
	Cost Center Description	Title XVIII	Hospi tal	PPS	· •
			-	1.00	
	PART I - ALL PROVIDER COMPONENTS				+
1.00	Inpatient days (including private room days and swing			1, 754	
2.00 3.00	Inpatient days (including private room days, excluding Private room days (excluding swing-bed and observation		ivate room days	1, 754 0	
	do not complete this line.	<u> </u>	rvate room days,		
4.00 5.00	Semi-private room days (excluding swing-bed and observ Total swing-bed SNF type inpatient days (including pri		or 21 of the cost	1, 520 0	
5.00	reporting period	TVate Toolin days) through becembe	a si oi the cost	0	5.0
6.00	Total swing-bed SNF type inpatient days (including pri		31 of the cost	0	6.00
7.00	reporting period (if calendar year, enter 0 on this li Total swing-bed NF type inpatient days (including priv		31 of the cost	0	7.0
	reporting period				
8.00	Total swing-bed NF type inpatient days (including priving period (if calendar year, enter 0 on this li		1 of the cost	0	8.0
9.00	Total inpatient days including private room days appli		swing-bed and	674	9.00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title	Will only (including private r	com davc)	0	10.00
10.00	through December 31 of the cost reporting period (see		oom days)	0	10.0
11.00	Swing-bed SNF type inpatient days applicable to title		room days) after	0	11.0
12.00	December 31 of the cost reporting period (if calendar Swing-bed NF type inpatient days applicable to titles		e room days)	0	12.0
	through December 31 of the cost reporting period		5 /		
13.00	Swing-bed NF type inpatient days applicable to titles after December 31 of the cost reporting period (if cal			0	13.0
	Medically necessary private room days applicable to the	he Program (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
10.00	SWING BED ADJUSTMENT		I	0	10.00
17.00	Medicare rate for swing-bed SNF services applicable to	o services through December 31 o	of the cost	0.00	17.0
18.00	reporting period Medicare rate for swing-bed SNF services applicable to	o services after December 31 of	the cost	0.00	18.0
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to	sorvices through December 21 of	the cost	0.00	19.0
	reporting period	0			
20. 00	Medicaid rate for swing-bed NF services applicable to reporting period	services after December 31 of t	he cost	0.00	20.0
21.00	Total general inpatient routine service cost (see ins	tructions)		2, 720, 389	21.0
22.00	Swing-bed cost applicable to SNF type services through 5×1 ine 17)	h December 31 of the cost report	ing period (line	0	22.0
23.00	Swing-bed cost applicable to SNF type services after I	December 31 of the cost reportir	ng period (line 6	0	23.0
24 00	x line 18)	December 21 of the east report	ng portion (Line		24.0
24.00	Swing-bed cost applicable to NF type services through $(7 \times 1)^{10}$ x line 19)	becember 31 of the cost report	ng period (inne	0	24.0
25.00	Swing-bed cost applicable to NF type services after De	ecember 31 of the cost reporting	period (line 8	0	25.0
26.00	x line 20) Total swing-bed cost (see instructions)			0	26.0
	General inpatient routine service cost net of swing-be	ed cost (line 21 minus line 26)		2, 720, 389	27.0
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding s	swing-bed and observation bed ch	arges)	0	28.0
29.00	Private room charges (excluding swing-bed charges)	swing bed and observation bed er	lui geo)	0	
	Semi-private room charges (excluding swing-bed charges			0	
31.00 32.00	General inpatient routine service cost/charge ratio (Average private room per diem charge (line 29 ÷ line 3			0. 000000 0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ 1			0.00	
34.00	Average per diem private room charge differential (lin		tions)	0.00	
35.00	Average per diem private room cost differential (line			0.00	
36.00	Private room cost differential adjustment (line 3 x li			0	36.0
37.00	General inpatient routine service cost net of swing-be		fferential (line	2, 720, 389	
	27 minus Line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH (1
38.00	Adjusted general inpatient routine service cost per di	, ,		1, 550. 96	
	Program general inpatient routine service cost (line Medically necessary private room cost applicable to the	-		1, 045, 347 0	39.0 40.0

OMPUT	Financial Systems TATION OF INPATIENT OPERATING COST		<u>HOSPITAL</u> Provider C	CN: 15-0102	Peri od:	eu of Form CMS- Worksheet D-1	
					From 01/01/2020 To 12/31/2020		
			Title	XVIII	Hospi tal	PPS	27 pm
	Cost Center Description	Total Inpatient CostIr	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	+
. 00		0	C	0.	00 0	C) 42.
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT		0	0.	00 0	0) 43.
. 00	CORONARY CARE UNIT	0	U	0.	00 0		43.
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGICAL INTENSIVE CARE UNIT						46
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			742, 448	3 48
. 00				ns)		1, 787, 795	
	PASS THROUGH COST ADJUSTMENTS						
. 00	[·	atient routine se	ervices (from	Wkst. D, su	m of Parts I and	63, 349	9 50
. 00	<pre>III) Pass through costs applicable to Program inp</pre>	atient ancillary	services (fr	om Wkst D	sum of Parts II	27, 222	2 51
	and IV)		001 11 000 (11				
. 00	Total Program excludable cost (sum of lines					90, 571	
8. 00	Total Program inpatient operating cost exclu	5 1	ated, non-phy	sician anest	netist, and	1, 697, 224	1 53
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	J∠)					
. 00						C	54
. 00	Target amount per discharge					0.00	55
. 00	Target amount (line 54 x line 55)					C	
. 00	Difference between adjusted inpatient operat	line 53)	C				
. 00 . 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period e	nding 1996 u	ndated and c	ompounded by the	0.00	
. 00	market basket	por tring period ci	iding 1770, c		shipounded by the	0.00	/ <i>`</i> /
. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
. 00	If line 53/54 is less than the lower of line					C) 61
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		(TTHES 54 X	60), OF 1% 0	i the target		
. 00						C	62
. 00		ent (see instruc ⁻	tions)			C) 63
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	to through Docom		aget report	ing pariod (See) 64
. 00	instructions) (title XVIII only)	ts through becen		cost report	ng period (see		64
. 00		ts after December	r 31 of the c	ost reportin	g period (See	C	65
	<pre>instructions)(title XVIII only)</pre>						
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	4 plus line 6	5)(title XVI	ll only). For	C) 66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through (December 31 c	f the cost r	eporting period	C	67
	(line 12 x line 19)	o oooto tiirougii i			opor tring por rou		
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after Dec	cember 31 of	the cost rep	orting period	C	68 (
00	(line 13 x line 20)	routino costs (li	no 47 i line	40)			40
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					C) 69
. 00	Skilled nursing facility/other nursing facil)		70
. 00	Adjusted general inpatient routine service c		ne 70 ÷ line	2)			71
. 00	5		(1. 44 1.	25)			72
. 00 . 00	Medically necessary private room cost applic Total Program general inpatient routine serv			ne 35)			73
. 00	Capital -related cost allocated to inpatient	•		orksheet B.	Part II, column		75
	26, line 45)		,		· · · · ·		
. 00	Per diem capital-related costs (line 75 ÷ li						76
. 00	Program capital -related costs (line 9 x line						77
00 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovider record	s)			78
00	Total Program routine service costs for comp	· ·		,	nus line 79)		80
00	Inpatient routine service cost per diem limi			-	,		81
00	Inpatient routine service cost limitation (I						82
. 00	Reasonable inpatient routine service costs ()				83
. 00 . 00	Program inpatient ancillary services (see in Utilization review - physician compensation		5)				84
. 00	1 5 1						86
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					
7.00	Total observation bed days (see instructions					234	
3.00	Adjusted general inpatient routine cost per		ine 2)			1, 550. 96	
00	Observation bed cost (line 87 x line 88) (se	a instructions)				362, 925	

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2020	Worksheet D-1	
				To 12/31/2020		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(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	164, 850	2, 720, 389	0.06059	8 362, 925	21, 993	90.00
91.00 Nursing School cost	0	2, 720, 389	0.00000	0 362, 925	0	91.00
92.00 Allied health cost	0	2, 720, 389	0.00000	0 362, 925	0	92.00
93.00 All other Medical Education	0	2, 720, 389	0.00000			93.00

COMPUT	Financial Systems STARKE MEMORIAL ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0102	Peri od: From 01/01/2020 To 12/31/2020	u of Form CMS-2 Worksheet D-1 Date/Time Prep 7/29/2021 3:27	pared:
	Cost Costor Description	Title XIX	Hospi tal	PPS	-
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	Inpatient days (including private room days and swing-bed day	s, excluding newborn)		1, 754	1.00
2.00	Inpatient days (including private room days, excluding swing-			1, 754	2.00
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	rivate room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		1, 520	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	0	5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private ro	om davs) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	5		-	
7.00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December	31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to newborn days) (see instructions)	o the Program (excluding	g swing-bed and	47	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.00
11.00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		coom days) after	o	11.00
11.00	December 31 of the cost reporting period (if calendar year, e		oom days) arter	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI.	X only (including privat	e room days)	0	12.00
13.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI.	X only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y	ear, enter O on this lir	ne)	-	
14.00 15.00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14.00 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 servic reporting period	es through December 31 c	of the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18.00
19.00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through Docombor 21 of	the cost	0.00	19.00
19.00	reporting period	s through becember 31 of	the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of t	he cost	0.00	20.00
21.00	Total general inpatient routine service cost (see instruction	s)		2, 720, 389	21.00
22.00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	0	22.00
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	na period (line 6	0	23.00
20.00	x line 18)			0	20.00
24.00	Swing-bed cost applicable to NF type services through Decembe 7×10^{-1} x line 19)	r 31 of the cost reporti	ng period (line	0	24.00
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.00
26.00	x line 20) Total swing-bed cost (see instructions)			o	26.00
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 720, 389	28.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00 29.00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed ch	narges)	0	28.00 29.00
	Semi-private room charges (excluding swing-bed charges)			0	30.00
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	31.00
32.00 33.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	32.00 33.00
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	ctions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x li			0.00	35.00
36.00 37.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 2, 720, 389	36.00 37.00
37.00	27 minus line 36)			2,720,307	57.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	DROCRAM INDATIENT ODEDATING COST REFORE DASS TUDOUCU COST AD U	LICTMENITC			
38.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 550. 96	38.00
38. 00 39. 00 40. 00		instructions) 38)		1, 550. 96 72, 895 0	38. 00 39. 00 40. 00

UMPUT	ATION OF INPATIENT OPERATING COST		L HOSPITAL Provider C	CN: 15-0102	Peri od:	worksheet D-1	
					From 01/01/2020 To 12/31/2020		epare
				e XIX	Hospi tal	7/29/2021 3:2 PPS	27 pm
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient CostI	npatient Days		÷	(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4)	
2.00	NURSERY (title V & XIX only)	0	0) 42.
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	0	0.	00 0	l c) 43.
. 00	CORONARY CARE UNIT	0	0	0.	00 0		43.
5.00	BURN INTENSIVE CARE UNIT						45.
	SURGICAL INTENSIVE CARE UNIT						46.
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
						1.00	
. 00	Program inpatient ancillary service cost (Wk			```		74, 737	
. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	ee instructio	ins)		147, 632	2 49.
0. 00	Pass through costs applicable to Program inp	atient routine s	ervices (from	Wkst. D, su	m of Parts I and	4, 418	3 50.
~~							
I. 00	Pass through costs applicable to Program inp. and IV)	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	2, 781	1 51.
2.00	Total Program excludable cost (sum of lines	50 and 51)				7, 199	52.
3.00	Total Program inpatient operating cost exclu		ated, non-phy	sician anest	hetist, and	140, 433	3 53.
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
. 00	Program discharges					C	54
. 00	Target amount per discharge					0.00	55
. 00	Target amount (line 54 x line 55)	1	C				
. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	get amount (I	ine 56 minus	line 53)		
0.00	Lesser of lines 53/54 or 55 from the cost re	porting period e	nding 1996, u	pdated and c	ompounded by the		
	market basket						
). 00 . 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line					0.00	
1.00	which operating costs (line 53) are less that						
	amount (line 56), otherwise enter zero (see	instructions)			Ū		
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (coo instruc	tions)				
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST						03
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	e cost report	ing period (See	C	64
5. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	to after Decembe	r 21 of the c	act reportin	a pariod (Saa	c c) 65.
5.00	instructions) (title XVIII only)	ts after Decembe		ost reportin	y period (see		00.
5.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVI	II only). For	C C	66.
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	o costs through	December 21 a	f the cost r	oporting poriod	c c) 67.
. 00	(line 12 x line 19)	e costs through	December 31 C	in the cost i	eporting period		07.
3.00	Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost rep	orting period	C	68.
00 0	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (1	ine 67 + line	(8)			69.
. 00	PART III - SKILLED NURSING FACILITY, OTHER N						
. 00	Skilled nursing facility/other nursing facil	3)		70
. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ne /0 ÷ line	2)			71
. 00	Medically necessary private room cost applic		(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine serv	•					74
6.00	Capital -related cost allocated to inpatient	routine service	costs (from W	lorksheet B,	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76
. 00	Program capital -related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minu		- data -				78
. 00 . 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp.	x 1		· ·	nus line 79)		79
. 00	Inpatient routine service cost per diem limi						81
. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82
. 00	Reasonable inpatient routine service costs ()				83
. 00 . 00	Program inpatient ancillary services (see in Utilization review - physician compensation		s)				84 85
b. 00	Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
7.00	Total observation bed days (see instructions					234	
B. 00	Adjusted general inpatient routine cost per	diem (line 27 ·	line 21			1, 550. 96	51 00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2020	Worksheet D-1	
				To 12/31/2020		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(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	164, 850	2, 720, 389	0.06059	8 362, 925	21, 993	90.00
91.00 Nursing School cost	0	2, 720, 389	0.00000	0 362, 925	0	91.00
92.00 Allied health cost	0	2, 720, 389	0.00000	0 362, 925	0	92.00
93.00 All other Medical Education	0	2, 720, 389	0. 00000			93.00

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0102	Peri od:	Worksheet D-3	6
			From 01/01/2020		
			To 12/31/2020	Date/Time Pre 7/29/2021 3:2	
	Titl€	e XVIII	Hospi tal	PPS	., b
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
0. 00 03000 ADULTS & PEDI ATRI CS			1, 501, 298		30. C
. 00 03100 INTENSIVE CARE UNIT			0		31.0
0. 00 04000 SUBPROVIDER - IPF			0		40. C
. 00 04100 SUBPROVI DER – I RF			0		41. C
8. 00 04300 NURSERY					43. C
ANCI LLARY SERVI CE COST CENTERS		1			-
0. 00 05000 OPERATING ROOM		0. 2060		41, 079	
. 00 05100 RECOVERY ROOM		0.0000		0	
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
8. 00 05300 ANESTHESI OLOGY 9. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0046			
. 00 05400 RADI 0L0GY-DI AGNOSTI C . 01 05401 ULTRASOUND		0. 3364		26, 725 3, 533	
5. 00 05500 RADI OLOGY-THERAPEUTI C		0.0783		3, 333	
0. 00 05500 RADI 0L001 - THERAPEUTIC		0. 1133		0	
7. 00 05700 CT SCAN		0. 0216		9, 668	
B. 00 05800 MRI		0.0624			
2. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
0. 00 06000 LABORATORY		0. 1279			
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		0	
00 06400 I NTRAVENOUS THERAPY		0.0000		0	
5. 00 06500 RESPI RATORY THERAPY		1. 1680		164, 207	65. C
0. 00 06600 PHYSI CAL THERAPY		0. 3373	45 125, 310	42, 273	66. C
2. 00 06700 OCCUPATI ONAL THERAPY		0.0000		0	67.0
B. 00 06800 SPEECH PATHOLOGY		0.0000	00 0	0	68.0
2. 00 06900 ELECTROCARDI OLOGY		0.0840		15, 234	69.0
0. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0502			
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 0992		0	1
8. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1407		131, 382	
4. 00 07400 RENAL DI ALYSI S		0.0000		0	
5. 00 07500 ASC (NON-DISTINCT PART)		0.0000			
0.00 03030 ANGI OCARDI OGRAPHY OUTPATI ENT SERVI CE COST CENTERS		0.0000	00 0	0	76. C
B. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88. 0
2. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
0. 00 09000 CLINIC		0.0000		0	
. 00 09100 EMERGENCY		0. 2110			
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1.3906			
OTHER REIMBURSABLE COST CENTERS					1
. 00 09400 HOME PROGRAM DI ALYSI S		0.0000	00 0	0	94. C
5. 00 09500 AMBULANCE SERVI CES					95. C
0. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0.0000	00 0	0	96. (
2. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0.0000	00 0	0	
00.00 Total (sum of lines 50 through 94 and 96 through 98)			3, 629, 065	742, 448	
11.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201.0
02.00 Net charges (line 200 minus line 201)			3, 629, 065		202.0

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0102	Peri od:	Worksheet D-3	2552-
ATTENT ANOTEEART SERVICE COST ATTORTONNENT	in ovraci e	011. 10 0102	From 01/01/2020		,
			To 12/31/2020		
	Titl	e XIX	Hospi tal	7/29/2021 3:2 PPS	27 piii
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
		-	Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			122, 575	[30.
I. OO OSIOO ADDETS & PEDIATRICS			122, 575		31.
0. 00 04000 SUBPROVIDER - IPF			0		40.
I. 00 04100 SUBPROVI DER - I RF			0		40.
3. 00 04300 NURSERY			0		41.
ANCI LLARY SERVICE COST CENTERS			0		- 43.
0. 00 05000 OPERATI NG ROOM		0. 2060	54 45, 893	9, 456	50.
I. OO O5100 RECOVERY ROOM		0.0000			
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000			
3. 00 05300 ANESTHESI OLOGY		0.0046			
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 3364			
4. 01 05401 ULTRASOUND		0.0763			
5. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000			
5. 00 05600 RADI OI SOTOPE		0. 1133		-	
7. 00 05700 CT SCAN		0. 0216		-	
3. 00 05800 MRI		0.0624			
9. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000			
0. 00 06000 LABORATORY		0. 1279		-	
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000			
1. 00 06400 I NTRAVENOUS THERAPY		0.0000			
5. 00 06500 RESPI RATORY THERAPY		1. 1680			
5. 00 06600 PHYSI CAL THERAPY		0. 3373			
7. 00 06700 OCCUPATIONAL THERAPY		0.0000			
3. 00 06800 SPEECH PATHOLOGY		0.0000		-	
9. 00 06900 ELECTROCARDI OLOGY		0. 0840		-	
0. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
I. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0502		-	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 0992		0	
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1407			
1. 00 07400 RENAL DIALYSIS		0.0000			
5. 00 07500 ASC (NON-DI STINCT PART)		0.0000			
5. 00 03030 ANGI OCARDI OGRAPHY		0.0000			
OUTPATIENT SERVICE COST CENTERS					
3. 00 08800 RURAL HEALTH CLINIC		0.0000	00 0	0	88.
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	00 0	0	89.
D. 00 09000 CLINIC		0.0000	00 0	0	90.
I. 00 09100 EMERGENCY		0. 2110	81 57, 734	12, 187	91.
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 3906	88 2, 076	2, 887	92.
OTHER REIMBURSABLE COST CENTERS		1		1	
4. 00 09400 HOME PROGRAM DI ALYSI S		0.0000	00 0	0	
5. 00 09500 AMBULANCE SERVICES					95.
5. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.0000			
7. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0.0000		0	
00.00 Total (sum of lines 50 through 94 and 96 through 98)			422, 915		
01.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.
02.00 Net charges (line 200 minus line 201)		1	422, 915	1	202.

ALCUL	Financial Systems STARKE MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-0102	Peri od: From 01/01/2020 To 12/31/2020		pared
		Title XVIII	Hospi tal	7/29/2021 3:2 PPS	7 pm
			nospi tui		
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
00 01	DRG amounts other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ing prior to October 1 ((see	0 731, 361	1.0
02	instructions) DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	340, 462	1. (
03	instructions) DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions)	prior to October	0	1.0	
04	DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	or discharges occurring	on or after	0	1.0
00 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.0
02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	2.0
03	Outlier payments for discharges occurring prior to October 1	-		0	2.0
04	Outlier payments for discharges occurring on or after October	1 (see instructions)		0	2.0
00 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repo	rting pariod (soo instru	uctions)	952, 138 14. 36	
00	Indirect Medical Education Adjustment	ting period (see filstic		14.30	4.
00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	0.00	5.
00	FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e)			0.00	6.
00 01	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.	0. 00 0. 00			
00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.		
01	The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	0.00			
02 00	The amount of increase if the hospital was awarded FTE cap sl under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin	-	0.00		
0.00	FTE count for allopathic and osteopathic programs in the curr			0.00	
1.00	FTE count for residents in dental and podiatric programs.			0.00	
2.00 3.00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0.00 0.00	
. 00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ar ended on or after Sep	otember 30, 1997,	0.00	
5.00	Sum of lines 12 through 14 divided by 3.			0.00	15.
5.00	Adjustment for residents in initial years of the program			0.00	
7.00 3.00	Adjustment for residents displaced by program or hospital clo Adjusted rolling average FTE count	sure		0.00 0.00	
	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	
0. 00	Prior year resident to bed ratio (see instructions)	,		0.000000	
. 00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
2. 00 2. 01	IME payment adjustment (see instructions)			0	22.
. 00	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42. Number of additional allopathic and osteopathic IME FTE resid		CFR 412.105	0.00	
. 00	(f)(1)(iv)(C) IME FTE Resident Count Over Cap (see instructions)	·		0.00	24.
. 00	If the amount on line 24 is greater than -O-, then enter the instructions) Resident to bed ratio (divide line 25 by line 4)	lower of line 23 or line	e 24 (see	0.00	
00	IME payments adjustment factor. (see instructions)			0.000000	
. 00	IME add-on adjustment amount (see instructions)			0	
. 01	IME add-on adjustment amount - Managed Care (see instructions)		0	
. 00 . 01	Total IME payment (sum of lines 22 and 28) <u>Total IME payment - Managed Care (sum of lines 22.01 and 28.0</u> Disproportionate Share Adjustment	0			
0. 00	Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instruc	ctions)	3.12	30.
. 00	Percentage of Medicaid patient days (see instructions)			21.78	
2.00	Sum of lines 30 and 31			24.90	32.
3.00	Allowable disproportionate share percentage (see instructions			9.76	33.

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0102	Period: From 01/01/2020	Worksheet E Part A	
			To 12/31/2020		
		Title XVIII	Hospi tal	PPS	/ piii
			Prior to 10/1		
	Uncomponsated Caro Adjustment		1.00	2.00	
5.00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		0	0	35. (
5. 01	Factor 3 (see instructions)		0. 00000000	0. 00000000	
5. 02	Hospital uncompensated care payment (If line 34 is zero, enter :	zero on this line) (see		285, 618	
	instructions)	74 004			
5.03 6.00	Pro rata share of the hospital uncompensated care payment amoun Total uncompensated care (sum of columns 1 and 2 on line 35.03)	t (see Instructions)	318, 637 390, 628	71, 991	35. 36.
0.00	Additional payment for high percentage of ESRD beneficiary discl	harges (lines 40 throug			30.
D. 00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684		0		40.
	instructions)				
1. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683	, 684 an 685. (see	0		41.
1. 01	instructions) Total ESRD Medicare covered and paid discharges excluding MS-DR	Ge 652 682 683 684	0		41. (
1.01	an 685. (see instructions)	03 052, 002, 003, 004	0		41.
2.00	Divide line 41 by line 40 (if less than 10%, you do not qualify	for adjustment)	0.00		42.
3.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0		43.
4 00	instructions)	Line 11 divided by 7	0,000000		4.4
4.00	Ratio of average length of stay to one week (line 43 divided by days)	Time 41 divided by 7	0. 000000		44.
5.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.
6.00	Total additional payment (line 45 times line 44 times line 41.0	1)	0		46.
7.00	Subtotal (see instructions)		1, 488, 603		47.
8.00	Hospital specific payments (to be completed by SCH and MDH, sma only. (see instructions)	II rural nospitals	1, 020, 735		48.
				Amount	
				1.00	
9.00	Total payment for inpatient operating costs (see instructions)			1, 488, 603	
D. 00 1. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. I			83, 638 0	50. 51.
2.00	Direct graduate medical education payment (from Wkst. E.4, line			0	52.
3.00	Nursing and Allied Health Managed Care payment			0	53.
4.00	Special add-on payments for new technologies			16, 641	
4.01	Islet isolation add-on payment			0	
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	ti ana)		0	
6.00 7.00	Cost of physicians' services in a teaching hospital (see intruc Routine service other pass through costs (from Wkst. D, Pt. III	-	rough 35)	0	56. 57.
B. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV		lough boy.	0	58.
9.00	Total (sum of amounts on lines 49 through 58)			1, 588, 882	59
D. 00	Primary payer payments			0	
1.00	Total amount payable for program beneficiaries (line 59 minus l	ine 60)		1, 588, 882	
2.00	Deductibles billed to program beneficiaries			192, 764	
3.00 4.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			2, 816 30, 384	
5.00	Adjusted reimbursable bad debts (see instructions)			19, 750	
5.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		30, 384	
7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			1, 413, 052	67.
3.00	Credits received from manufacturers for replaced devices for ap			0	
9.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (Final structures and ustructures (SEE INSTRUCTURES) (SEE(LEX))	or SCH see instructions)	0	
). 00). 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstra	tion) adjustment (see i	nstructions)	0	70
). 30). 87	Demonstration payment adjustment amount before sequestration	trony aujustillent (see I		0	70.
D. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.
D. 89	Pioneer ACO demonstration payment adjustment amount (see instru-	ctions)		-	70
D. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	
0.91	HSP bonus payment HRR adjustment amount (see instructions)			0	
D. 92 D. 93	Bundled Model 1 discount amount (see instructions)			0	70.
	HVBP payment adjustment amount (see instructions)			0	70.
0.93 0.94	HRR adjustment amount (see instructions)			-2, 374	70.

ALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CC	N: 15-0102	Period: From 01/01/2020		
			To 12/31/2020	7/29/2021 3:2	
	Title		Hospi tal	PPS	
	-	FFY	<u>(yyyy)</u> 0	Amount 1.00	
0.96 Low volume adjustment for federal fiscal year (yyyy) (Enter	in column O		2020	264, 099	70.96
the corresponding federal year for the period prior to 10/1)				
0.97 Low volume adjustment for federal fiscal year (yyyy) (Enter			2021	133, 122	70.97
the corresponding federal year for the period ending on or	after 10/1)			0	70.00
 D. 98 Low Volume Payment-3 D. 99 HAC adjustment amount (see instructions) 				0 14, 052	
1.00 Amount due provider (line 67 minus lines 68 plus/minus line	es 69 & 70)			1, 793, 847	
1.01 Sequestration adjustment (see instructions)	,			11, 839	71.0
1.02 Demonstration payment adjustment amount after sequestration	ı			0	
1.03 Sequestration adjustment-PARHM pass-throughs				4 /70 550	71.03
2.00 Interim payments				1, 679, 550	
2.01 Interim payments-PARHM 3.00 Tentative settlement (for contractor use only)				0	72.01
3.01 Tentative settlement-PARHM (for contractor use only)				0	73.01
4.00 Balance due provider/program (line 71 minus lines 71.01, 71	.02, 72, and			102, 458	
73)					
4.01 Balance due provider/program-PARHM (see instructions)					74.01
5.00 Protested amounts (nonallowable cost report items) in accor	dance with			169, 752	75.00
CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or su	um of 2.03			0	90.00
plus 2.04 (see instructions)					
1.00 Capital outlier from Wkst. L, Pt. I, line 2				0	
2.00 Operating outlier reconciliation adjustment amount (see ins				0	
3.00 Capital outlier reconciliation adjustment amount (see instr 4.00 The rate used to calculate the time value of money (see ins				0.00	
5.00 Time value of money for operating expenses (see instruction				0.00	1
5.00 Time value of money for capital related expenses (see instr				0	96.00
			Prior to 10/1		
HSP Bonus Payment Amount			1.00	2.00	
00.00 HSP bonus amount (see instructions)			0	0	100. 00
HVBP Adjustment for HSP Bonus Payment					1
01.00 HVBP adjustment factor (see instructions)			0. 000000000		
02.00 HVBP adjustment amount for HSP bonus payment (see instructi	ons)		0	0	102.00
HRR Adjustment for HSP Bonus Payment			0. 9969	0. 9997	1102 00
03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructio	ns)		0.9969		103.00
Rural Community Hospital Demonstration Project (§410A Demon		stment		0	104.00
00.00 Is this the first year of the current 5-year demonstration					200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.					1
Cost Reimbursement	1.5.5 (0)				1201 0
01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I 02.00 Medicare discharges (see instructions)	ine 49)				201.00
03. 00 Case-mix adjustment factor (see instructions)					202.0
Computation of Demonstration Target Amount Limitation (N/A	in first year o	of the curre	nt 5-year demonst	tration	
peri od)	-		-		
04.00 Medicare target amount					204.00
05.00 Case-mix adjusted target amount (line 203 times line 204) 06.00 Medicare inpatient routine cost cap (line 202 times line 20					205. 00 206. 00
Adjustment to Medicare Part A Inpatient Reimbursement					1200. 00
07.00 Program reimbursement under the §410A Demonstration (see in	nstructions)				207. 0
08.00 Medicare Part A inpatient service costs (from Wkst. E, Pt.					208.0
09.00 Adjustment to Medicare IPPS payments (see instructions)					209. 00
10.00 Reserved for future use					210. 0
11.00 Total adjustment to Medicare IPPS payments (see instruction	is)				211.0
Comparision of PPS versus Cost Reimbursement 12.00 Total adjustment to Medicare Part A IPPS payments (from lin	pe 211)				212. 0
13.00 Low-volume adjustment (see instructions)	ic 211)				212.0
			1		
18.00 Net Medicare Part A IPPS adjustment (difference between PPS	and cost reim	oursement)			218.0

	Financial Systems LUME CALCULATION EXHIBIT 4		STARKE MEMORI	Provider CC	F	eriod: rom 01/01/2020 o 12/31/2020	u of Form CMS-2 Worksheet E Part A Exhibi Date/Time Prep 7/29/2021 3:2	t 4 pare
		W/S E Dent 1	Amounto (free		XVIII Period Prior	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier	1.00	0	0	C		0	1
)1	payments DRG amounts other than outlier	1. 01	731, 361	О	731, 361		731, 361	1
)2	payments for discharges occurring prior to October 1 DRG amounts other than outlier	1. 02	340, 462	0		340, 462	340, 462	1
	payments for discharges occurring on or after October 1							
)3	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	Ο	C		0	1
4	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1
0	Outlier payments for	2.00						2
1	discharges (see instructions) Outlier payments for	2. 02	0	0	C	0	0	2
)2	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to	2. 03	О	0	С		0	2
)3	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2.04	0	0		0	0	2
0	instructions) Operating outlier reconciliation	2. 01	0	0	C	0	0	3
0	Managed care simulated payments	3.00	952, 138	0	802, 663	149, 475	952, 138	4
0	Indirect Medical Education Adju Amount from Worksheet E, Part	ustment 21.00	0. 000000	0. 000000	0. 000000	0.000000		15
0	A, line 21 (see instructions) IME payment adjustment (see	21.00	0.000000	0.000000	0.000000		0	
1	instructions) IME payment adjustment for managed care (see	22.01	0	0	C	0	0	6
0	instructions) Indirect Medical Education Adju IME payment adjustment factor	ustment for the 27.00	e Add-on for Sec 0. 000000	ction 422 of th 0.000000	ne MMA 0.000000	0. 000000		7
0	(see instructions) IME adjustment (see instructions)	28.00	0	0	C	0	0	6
)1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	C	0	0	8
00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	C	0	0	Ģ
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	C	0	0	ç
	Disproportionate Share Adjustme	ent	I			· · · · · ·		1
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0976	0. 0976	0. 0976	0. 0976		10
00	Disproportionate share adjustment (see instructions)	34.00	26, 152	0	17, 845	8, 307	26, 152	11
01	Uncompensated care payments	36.00	390, 628	0	248, 399	142, 229	390, 628	11
00	Additional payment for high per Total ESRD additional payment (see instructions)	46.00	0 Deneri ci ary (di scharges 0	C	0	0	12
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	1, 488, 603 0	0 0	997, 605 C	490, 998 0	1, 488, 603 0	
00	(see instructions) Total payment for inpatient operating costs (see	49.00	1, 488, 603	0	997, 605	490, 998	1, 488, 603	15
00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	83, 638	0	58, 789	24, 849	83, 638	16

	Financial Systems		STARKE MEMORI				u of Form CMS-2	2552-1
LOW VO	LUME CALCULATION EXHIBIT 4			Provider CC		Period: From 01/01/2020 To 12/31/2020		pared:
				Title	XVIII	Hospi tal	PPS	7 pm
		W/S E. Part A	Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	16, 641	0		0 16, 641	16, 641	17.0
17.01 17.02	Net organ aquisition cost Credits received from manufacturers for replaced	68.00	0	0		0 0	0	17.0 17.0
8.00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	18.0
19.00	SUBTOTAL			0	1, 056, 39	4 532, 488	1, 588, 882	19.0
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1.00 1.01	82, 498 0	0 0	57, 93	6 24, 562 0 0	82, 498 0	
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG	2. 00 2. 01	1, 140 0	0 0	85	3 287 0 0	1, 140 0	
2. 00	outlier payments Indirect medical education percentage (see instructions)	5.00	0. 0000	0. 0000	0.000	0.0000		22.0
23. 00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23.0
.400	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.000	0.0000		24.0
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25.0
26.00	Total prospective capital payments (see instructions)	12.00	83, 638	0	58, 78	9 24, 849	83, 638	26.0
		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. 25000			27.0
8. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			264, 09	9	264, 099	28.0
9. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				133, 122	133, 122	29.0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 0

	Financial Systems AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	<u>STARKE MEMORI</u> FION EXHIBIT 5	Provider CC	F	Period: From 01/01/2020 To 12/31/2020	Date/Time Prep 7/29/2021 3:2	t 5 pared:
		Wkst. E, Pt. A, line	Title Amt. from Wkst. E, Pt.	Period to 10/01	Hospi tal Peri od on after 10/01	PPS Total (cols. 2 and 3)	
		0	A) 1.00	2.00	3.00	4.00	
. 00	DRG amounts other than outlier payments	1.00	1.00	2.00	3.00	4.00	1.00
. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	731, 361	731, 361		731, 361	1.01
. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	340, 462		340, 462	340, 462	1. 02
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0	C		0	1. 03
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1.04	0		0	0	1. 04
. 00	October 1 Outlier payments for discharges (see instructions)	2.00					2.00
. 01	Outlier payments for discharges for Model 4 BPCI	2.02	0	C	0 0	0	2. 01
02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	C)	0	2. 02
03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2. 03
00	Operating outlier reconciliation	2.01	0	C	0 0	0	3.00
00	Managed care simulated payments	3.00	952, 138	802, 663	3 149, 475	952, 138	4.00
. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000	0. 000000		5.0
00 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22.00 22.01	0 0	C		0 0	6. 00 6. 01
	instructions)			- 1414.4			
00	Indirect Medical Education Adjustment for the IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 000000	0. 000000		7.0
00 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28.00 28.01	0 0	C	0 0 0 0	0 0	8. 0 8. 0
00 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 00 29. 01	0 0	C		0 0	9. 0 9. 0
	Di sproporti onate Share Adjustment		1 1				
. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0976	0. 0976	0. 0976		10. C
. 00	Disproportionate share adjustment (see instructions)	34.00	26, 152	17, 845		26, 152	
. 01	Uncompensated care payments	36.00	390, 628	318, 637	71, 991	390, 628	11. C
2. 00	Additional payment for high percentage of ESR Total ESRD additional payment (see instructions)	46.00	di scharges	(0 0	0	12.0
8.00	Subtotal (see instructions)	47.00	1, 488, 603	1, 067, 843	420, 760	1, 488, 603	13.0
. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48.00	0	C	0	0	14. C
. 00	instructions) Total payment for inpatient operating costs	49.00	1, 488, 603	1, 067, 843	420, 760	1, 488, 603	15.0
o. 00	(see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	83, 638	62, 614	21, 024	83, 638	16. 0
7.00 7.01	Special add-on payments for new technologies Net organ acquisition cost	54.00	16, 641	12, 458	4, 183	16, 641	17.0 17.0
. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	C	0	0	
3. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	C		0	18. 0
9.00	SUBTOTAL			1, 142, 915	445, 967	1, 588, 882	19.0

Health Financial Systems	STARKE MEMORI			In Lie	u of Form CMS-	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCU	JLATION EXHIBIT 5	Provider C	CN: 15-0102	Period: From 01/01/2020 To 12/31/2020		pared:
		Title	XVIII	Hospi tal	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	82, 498			82, 498	20.00
20.01 Model 4 BPCI Capital DRG other than outlie		0		0 0		
21.00 Capital DRG outlier payments	2.00	1, 140	85	53 287	1, 140	
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	
22.00 Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0.0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00 Allowable disproportionate share percentag (see instructions)	je 10.00	0.0000	0.000	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	83, 638	62, 61	14 21, 024	83, 638	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	264, 099	264, 04	99	264, 099	28.00
29.00 Low volume adjustment on or after October	1 70.97	133, 122		133, 122	133, 122	29.00
30.00 HVBP payment adjustment (see instructions)	70.93	0		0 0	0	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	-2, 374	-1, 7	-597	-2.374	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	
					(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		14, 0	52 0	14, 052	32.00
100.00 Transfer HAC Reduction Program adjustment Wkst. E. Pt. A.	to	Y				100.00

	Financial Systems STARKE MEMORIAL HOSPI ATI ON OF REIMBURSEMENT SETTLEMENT Provi	TAL der CCN: 15-0102	In Lie Period: From 01/01/2020 To 12/31/2020		pared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			4, 951	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			1, 987, 184	
3.00 4.00	OPPS payments			1, 506, 056 0	3.00 4.00
4.00 4.01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	
6.00	Line 2 times line 5			0	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, co	13 line 200		0	
10.00	Organ acqui si ti ons	1. 10, 1110 200		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4, 951	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			35, 294	12 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)	, 		35, 294	14.00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for paymen			0	
16.00	Amounts that would have been realized from patients liable for paym had such payment been made in accordance with 42 CFR §413.13(e)	ent for services of	n a chargebasis	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)			35, 294	
19.00	Excess of customary charges over reasonable cost (complete only if	line 18 exceeds li	ne 11) (see	30, 343	19.00
20.00	instructions) Excess of reasonable cost over customary charges (complete only if	line 11 exceeds li	ne 18) (see	0	20.00
	instructions)				
21.00	Lesser of cost or charges (see instructions)			4, 951	
22.00 23.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructio	nc)		0	22.00 23.00
23.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	113)		1, 506, 056	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	c		120	
26.00 27.00	Deductibles and Coinsurance amounts relating to amount on line 24 (Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus t			302, 025 1, 208, 862	
27.00	instructions)		25] (366	1, 200, 002	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	
30.00 31.00	Subtotal (sum of lines 27 through 29) Primary payer payments			1, 208, 862 702	
32.00	Subtotal (line 30 minus line 31)			1, 208, 160	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
	Composite rate ESRD (from Wkst. I-5, line 11)				33.00
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			67, 493 43, 870	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructio	ns)		65, 102	
37.00	Subtotal (see instructions)			1, 252, 030	
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50 39.97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	39.50 39.97
39.98	Partial or full credits received from manufacturers for replaced de	vices (see instru	tions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION		,	0	
40.00	Subtotal (see instructions)			1, 252, 030	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			8, 263 0	
40.02	Sequestration adjustment-PARHM pass-throughs				40.02
	Interim payments			1, 201, 816	
41.01	Interim payments-PARHM				41.01
42.00	Tentative settlement (for contractors use only)			0	
42.01 43.00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			41, 951	42.01
43.00	Balance due provider/program-PARHM (see instructions)			11, 751	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub. 15-2,	chapter 1,	0	
	\$115.2 TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	
93.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00 94.00
74. UU				0	1 74. UU

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0102	Period: From 01/01/2020 To 12/31/2020		
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider 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 List separately each retroactive lump sum adjustment		1, 679, 55	50 0	1, 201, 816 0	1. 0 2. 0 3. 0
00	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) Program to Provider					5.0
01	ADJUSTMENTS TO PROVIDER			0	0	3. C
02				0	0	3. C
03				0	0	3. (
04 05				0	0	3. 3.
05	Provider to Program			0	0	J.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53				0	0	3.
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 3.
99	3. 50-3. 98)			0	U	3.
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, 679, 55	50	1, 201, 816	4.
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01	TENTATI VE TO PROVI DER			0	0	5.
02				0	0	5.
03				0	0	5.
~	Provider to Program					-
50 51	TENTATI VE TO PROGRAM			0	0	5. 5.
52				0	0	5. 5.
99 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)		100 1		41 051	6
)1)2	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		102, 45	0	41, 951 0	6. 6.
)2)0	Total Medicare program liability (see instructions)		1, 782, 00	-	0 1, 243, 767	6. 7.
				Contractor Number	NPR Date (Mo/Day/Yr)	,
)	1.00	2.00	

Heal th	Financial Systems STARKE MEMORI	AL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0102	Peri od: From 01/01/2020 To 12/31/2020		pared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI	ON			
1.00	Total hospital discharges as defined in AARA §4102 from Wks	st. S-3, Pt. I col. 15 line	e 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	3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	f certified HIT technology	Wkst. S-2, Pt. I		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	on (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				1
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	d line 31) (see instruction	ns)		32.00

		HOSPITAL Provider CCN: 15-0102	Peri od:	u of Form CMS-2 Worksheet E-3	
CALCUL	ATTON OF REIMBORSEMENT SETTLEMENT	Provider CCN. 15-0102	From 01/01/2020	Part VII	
			To 12/31/2020	Date/Time Pre 7/29/2021 3:2	
		Title XIX	Hospi tal	PPS	<u>, bui</u>
			Inpati ent	Outpati ent	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	LCES FOR TITLES V OR Y		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	VICES FOR TITLES V OR A	IX SERVICES		
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			272, 855	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	272, 855	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00 7.00	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)		0	0	6.00 7.00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		0	272, 855	7.00
	Reasonable Charges				
8.00	Routine service charges		122, 575		8.00
9.00	Ancillary service charges		422, 915	1, 752, 008	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)		545, 490	1, 752, 008	12.00
13.00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
13.00	basi s	services on a charge	0	0	15.00
14.00	Amounts that would have been realized from patients liable for	payment for services o	n 0	0	14.00
	a charge basis had such payment been made in accordance with 42				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.00000	0.00000	
16.00	Total customary charges (see instructions)		545, 490	1, 752, 008	
17.00	Excess of customary charges over reasonable cost (complete only line 4) (see instructions)	y IT IINE 16 exceeds	545, 490	1, 479, 153	17.00
18.00	Excess of reasonable cost over customary charges (complete only	vifline 4 exceeds lin	e 0	0	18.00
10.00	16) (see instructions)		° °	0	10.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instru		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 10		0	272, 855	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be of	completed for PPS provi			
22.00	Other than outlier payments		0	0	22.00
23.00 24.00	Outlier payments Program capital payments		0	0	23.00 24.00
24.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	
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	272, 855	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0 272, 855	30.00
31.00 32.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		0	272,855	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
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	272, 855	36.00
37.00	ELIMINATE SETTLEMENT		0	-278, 426	37.00
38.00	Subtotal (line 36 ± line 37)		0	-5, 571	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	F 574	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	-5, 571	40.00
41.00 42.00	Interim payments Balance due provider/program (line 40 minus line 41)		0	0 -5, 571	41.00
42.00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2	0	-5, 571	

ANC	Financial Systems STARKE MEMORI. E SHEET (If you are nonproprietary and do not main natain	Provi der C		eriod: rom 01/01/2020	u of Form CMS-: Worksheet G	
nd-t y)	ype accounting records, complete the General Fund column		T		Date/Time Pre	pare
-		General Fund		Endowment Fund	7/29/2021 3:2 Plant Fund	
		1.00	Purpose Fund 2.00	3.00	4.00	
	CURRENT ASSETS					
00	Cash on hand in banks	72, 449		0	0	
00 00	Temporary investments Notes receivable		0	0	0	
00	Accounts receivable	-671, 241		0	0	
00	Other receivable	-071, 241	0	0	0	
00	Allowances for uncollectible notes and accounts receivable	-2, 857, 179	0	0	0	
00	Inventory	331, 970		0	0	
00	Prepaid expenses	109, 906	0	0	0	8
00	Other current assets	2, 028		0	0	
00	Due from other funds	0	0	0	0	10
00	Total current assets (sum of lines 1-10)	-3, 012, 067	0	0	0	11
	FI XED_ASSETS	-	-	-	-	
00	Land		0	0	0	
00	Land improvements	33, 465 -8, 087	0	0	0	
00	Accumulated depreciation Buildings	-0, 007	0	0	0	
00	Accumulated depreciation		0	0	0	16
00	Leasehold improvements	1, 409, 783	0	0	0	17
00	Accumulated depreciation	-674, 466	0	0	0	18
	Fixed equipment	30, 560	0	0	0	19
00	Accumulated depreciation	-30, 560	0	0	0	20
00	Automobiles and trucks	3, 610	0	0	0	21
00	Accumulated depreciation	-3, 610	0	0	0	22
	Major movable equipment	3, 259, 014	0	0	0	23
	Accumulated depreciation	-2, 566, 761	0	0	0	24
	Minor equipment depreciable	806, 014	0	0	0	25
	Accumulated depreciation	-540, 085	0	0	0	26
	HIT designated Assets		0	0	0	27
	Accumulated depreciation Minor equipment-nondepreciable		0	0	0	1
00	Total fixed assets (sum of lines 12-29)	1, 718, 877		0	0	
00	OTHER ASSETS	1, 710, 077	0	ų	0	1 30
00	Investments	0	0	0	0	31
00	Deposits on Leases	0	0	0	0	32
00	Due from owners/officers	0	0	0	0	33
00	Other assets	761, 075	0	0	0	34
00	Total other assets (sum of lines 31–34)	761, 075		0	0	
00	Total assets (sum of lines 11, 30, and 35)	-532, 115	0	0	0	36
	CURRENT LI ABI LI TI ES	1	1			
	Accounts payable	515, 629		0	0	
00	Salaries, wages, and fees payable	590, 997	0	0	0	
	Payroll taxes payable Notes and Loans payable (short term)	0 -260, 580	0	0	0	
	Deferred i ncome	-200, 580	0	0	0	
00	Accel erated payments		0	0	0	42
00	Due to other funds	-12, 390, 484	0	0	0	
00	Other current liabilities	1, 817, 377		0	0	
00	Total current liabilities (sum of lines 37 thru 44)	-9, 727, 061	0	0	0	
	LONG TERM LIABILITIES			· · ·		
00	Mortgage payable	0	0	0	0	46
00	Notes payable	0	0	0	0	
00	Unsecured Loans	0	0	0	0	
00	Other long term liabilities	290, 864		0	0	
00	Total long term liabilities (sum of lines 46 thru 49)	290, 864		0	0	
00	Total liabilities (sum of lines 45 and 50)	-9, 436, 197	0	0	0	51
~~	CAPITAL ACCOUNTS	0.004.000				1 - /
00	General fund balance	8, 904, 082	0			52
00 00	Specific purpose fund Donor created - endowment fund balance - restricted		0	0		53
00	Donor created - endowment fund balance - restricted			0		52
00	Governing body created - endowment fund balance			0		56
00	Plant fund balance - invested in plant			0	0	
00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				Ũ	
00	Total fund balances (sum of lines 52 thru 58)	8, 904, 082	0	0	0	59
						60

Health Financial Systems	STARKE MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
STATEMENT OF CHANGES IN FUND BALANCES		Provider CC		Peri od: From 01/01/2020 To 12/31/2020	Worksheet G-1 Date/Time Pre 7/29/2021 3:2	pared:
	General	Fund	Speci al	Purpose Fund	Endowment Fund	
1.00 Fund balances at beginning of period	1.00	2.00 3,839,620	3.00	4.00	5.00	1.00
2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 STOCK HOLDERS EQUITY 2905-150 5.00 6.00 7.00 8.00 9.00 10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 14.00 15.00 16.00	69, 488 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	69, 488 8, 904, 974 8, 834, 594			0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
 17.00 18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18) 	0	0 8, 904, 082		0 0 0	0	17. 00 18. 00 19. 00
	Endowment Fund	PI ant	Fund			
	6.00	7.00	8.00			
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 29)3.00Total (sum of line 1 and line 2)4.00STOCK HOLDERS EQUITY 2905-1505.006.007.008.009.009.00	0	000000000000000000000000000000000000000	0.00	0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)	000000000000000000000000000000000000000	0 0 0 0 0 0		0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

AIEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN:	15-0102		riod: om 01/01/2020 12/31/2020	Worksheet G-2 Parts I & II Date/Time Pre 7/29/2021 3:2	pared:
	Cost Center Description			Inpati ent		Outpati ent	Total	
				1.00		2.00	3.00	
	PART I – PATIENT REVENUES							
	General Inpatient Routine Services							
00	Hospi tal			4, 033, 1			4, 033, 170	
00	SUBPROVIDER - IPF				0		0	
00	SUBPROVIDER – IRF				0		0	
00	SUBPROVIDER							4.00
00	Swing bed - SNF				0		0	5.0
00	Swing bed - NF				0		0	
00	SKILLED NURSING FACILITY							7.00
00	NURSING FACILITY							8.0
00	OTHER LONG TERM CARE							9.0
. 00	Total general inpatient care services (sum of lines 1-9)			4, 033, 1	70		4, 033, 170	10.0
	Intensive Care Type Inpatient Hospital Services				-			
. 00	INTENSIVE CARE UNIT				0		0	
. 00	CORONARY CARE UNIT							12.0
. 00	BURN INTENSIVE CARE UNIT							13.0
. 00	SURGI CAL I NTENSI VE CARE UNI T							14.0
. 00	OTHER SPECIAL CARE (SPECIFY)				_		_	15.0
. 00	Total intensive care type inpatient hospital services (sum of	lines			0		0	16.0
~ ~	11-15)						4 000 470	17.0
. 00	Total inpatient routine care services (sum of lines 10 and 16)			4, 033, 1			4, 033, 170	
. 00	Anci I lary services			6, 943, 30		46, 676, 950	53, 620, 315	
. 00	Outpatient services			1, 318, 41		10, 681, 009	11, 999, 421	
. 00	RURAL HEALTH CLINIC				0	0	0	20.0
. 00	FEDERALLY QUALIFIED HEALTH CENTER				0	0	0	
. 00	HOME HEALTH AGENCY					0	0	
. 00	AMBULANCE SERVICES				0	0	0	
. 00	CMHC					0	0	
. 10	CORF				0	0	0	
. 00	AMBULATORY SURGICAL CENTER (D. P.)				0	0	0	
. 00	HOSPI CE				0	0	0	
. 00	OTHER (SPECIFY)	+- WI+		10 004 0	0	0	0	27.0
. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to wkst.		12, 294, 94	47	57, 357, 959	69, 652, 906	28.0
	G-3, line 1) PART II - OPERATING EXPENSES					l		-
. 00	Operating expenses (per Wkst. A, column 3, line 200)					13, 156, 115		29.0
. 00	ADD (SPECIFY)				0	13, 150, 115		30.0
. 00	ADD (SFECILI)				0			31.0
. 00					0			32.0
. 00					0			33.0
. 00					0			34.0
. 00					0			35.0
. 00	Total additions (sum of lines 30-35)				0	0		36.0
. 00	DEDUCT (SPECIFY)				0	0		37.0
. 00	DEDUCT (SFECITI)				0			38.0
. 00					0			39.0
. 00					0			40.0
. 00					0			40.0
. 00	Total deductions (sum of lines 37-41)				0	0		41.0
. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf				13, 156, 115		42.0
. 00	to Wkst. G-3, line 4)	Julansle	21			13, 150, 115		43.0

Heal th	Financial Systems STAR	KE MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES		Provi der	CCN: 15-0102	Peri od:	Worksheet G-3	
					From 01/01/2020 To 12/31/2020	Date/Time Pre	arod
					10 12/31/2020	7/29/2021 3:2	
						1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, co					69, 652, 906	1.00
2.00	Less contractual allowances and discounts on patie	ents' accoun	ts			53, 551, 815	2.00
3.00	Net patient revenues (line 1 minus line 2)					16, 101, 091	3.00
4.00	Less total operating expenses (from Wkst. G-2, Par		43)			13, 156, 115	4.00
5.00	Net income from service to patients (line 3 minus	line 4)				2, 944, 976	5.00
6.00	OTHER INCOME					0	6.00
8.00 7.00	Contributions, donations, bequests, etc Income from investments					0	6.00 7.00
7.00 8.00	Revenues from telephone and other miscellaneous co	mmunication	sorvi cos			0	7.00 8.00
8.00 9.00	Revenue from tel evision and radio service		Sel vi ces			0	9.00
10.00	Purchase di scounts					0	10.00
11.00	Rebates and refunds of expenses					0	11.00
12.00						0	12.00
13.00	Revenue from Laundry and Linen service					0	13.00
14.00	Revenue from meals sold to employees and guests					0	14.00
15.00						0	15.00
16.00	Revenue from sale of medical and surgical supplies	to other t	han patien [.]	ts		0	16.00
17.00	Revenue from sale of drugs to other than patients					0	17.00
18.00	Revenue from sale of medical records and abstracts					0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)					0	19.00
	Revenue from gifts, flowers, coffee shops, and can	iteen				0	20.00
	Rental of vending machines					0	21.00
22.00						0	22.00
23.00						0	23.00
24.00						256, 645	
	COVI D-19 PHE Funding					1, 793, 353	
	Total other income (sum of lines 6-24)					2,049,998	
	Total (line 5 plus line 25)					4, 994, 974	26.00
	OTHER EXPENSES (SPECIFY)	-)				0	27.00
	Total other expenses (sum of line 27 and subscript					0	28.00
29.00	Net income (or loss) for the period (line 26 minus	nine zo)			l	4, 994, 974	29.00

al th Financial Systems STARKE M LCULATION OF CAPITAL PAYMENT	MEMORIAL HOSPITAL Provider CCN: 15-0102	Period:	u of Form CMS-2 Worksheet L	2552-
LCOLATION OF CAPITAL PATMENT		From 01/01/2020 To 12/31/2020	Parts I-III	
	Title XVIII	Hospi tal	PPS	
			1 00	
PART I - FULLY PROSPECTIVE METHOD			1.00	
CAPITAL FEDERAL AMOUNT				1
00 Capital DRG other than outlier			82, 498] 1.
01 Model 4 BPCI Capital DRG other than outlier			0	1
00 Capital DRG outlier payments			1, 140	
01 Model 4 BPCI Capital DRG outlier payments			0	
00 Total inpatient days divided by number of days in the	cost reporting period (see ins	structions)	4.15	
00 Number of interns & residents (see instructions)	>		0.00	
00 Indirect medical education percentage (see instruction 00 Indirect medical education adjustment (multiply line 5		1 columns 1 and	0.00	
1.01) (see instructions)	by the sum of times f and i.c	n, corumns ranu	0	0.
00 Percentage of SSI recipient patient days to Medicare F 30) (see instructions)	Part A patient days (Worksheet	E, part A line	0.00	7.
00 Percentage of Medicaid patient days to total days (see	e instructions)		0.00	8.
00 Sum of lines 7 and 8			0.00	
.00 Allowable disproportionate share percentage (see instr	ructions)		0.00	
. 00 Disproportionate share adjustment (see instructions)			0	1
.00 Total prospective capital payments (see instructions)			83, 638	12.
			1.00	
PART II - PAYMENT UNDER REASONABLE COST				
00 Program inpatient routine capital cost (see instruction	ons)		0] 1.
00 Program inpatient ancillary capital cost (see instruct			0	1
00 Total inpatient program capital cost (line 1 plus line	e 2)		0	
00 Capital cost payment factor (see instructions)			0	
00 Total_inpatient_program_capital_cost (line 3_x line 4)	1		0	5.
			1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
00 Program inpatient capital costs (see instructions)	sumstances (coo instructions)		0	
00 Program inpatient capital costs for extraordinary circ 00 Net program inpatient capital costs (line 1 minus line			0	
00 Applicable exception percentage (see instructions)	5∠)		0.00	-
00 Capital cost for comparison to payments (line 3 x line	e 4)		0.00	
00 Percentage adjustment for extraordinary circumstances			0.00	
00 Adjustment to capital minimum payment level for extrac	ordinary circumstances (line 2	x line 6)	0	7
00 Capital minimum payment level (line 5 plus line 7)		-	0	8
00 Current year capital payments (from Part I, line 12, a			0	1 .
.00 Current year comparison of capital minimum payment lev			0	
.00 Carryover of accumulated capital minimum payment level Worksheet L, Part III, line 14)	over capital payment (from pr	ior year	0	11.
			0	
.00 Net comparison of capital minimum payment level to cap		ne)	0	
.00 Net comparison of capital minimum payment level to cap .00 Current year exception payment (if line 12 is positive				
 .00 Net comparison of capital minimum payment level to cap .00 Current year exception payment (if line 12 is positive .00 Carryover of accumulated capital minimum payment level 	over capital payment for the		0	14.
 Net comparison of capital minimum payment level to cap Current year exception payment (if line 12 is positive Carryover of accumulated capital minimum payment level (if line 12 is negative, enter the amount on this line) 	l over capital payment for the e)		-	
 Net comparison of capital minimum payment level to cap Ourrent year exception payment (if line 12 is positive Carryover of accumulated capital minimum payment level 	l over capital payment for the e) (see instructions)		0	15