		NESS GIBSO			u of Form CMS-25	52-10
	eport is required by law (42 USC 1395g; 42 CFR 413.20( s made since the beginning of the cost reporting perio				FORM APPROVED OMB NO. 0938-00 EXPIRES 03-31-2	
	AL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFI TLEMENT SUMMARY	CATION Pro	ovider CCN: 15-1319	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepa 2/28/2022 10:06	
PART I	- COST REPORT STATUS					
Provi de use on		number of	times the provider r	Date: 2/28/20		)6 am
	4. [F] Medicare Utilization. Enter "F" for ful	l or "L" f	for low.	esubili tteu this t	JUST TEPOTT	
Contrad use on	tor 5. [1]Cost Report Status 6. Date Received:	eport for t	10. N 11. C his Provider CCN 12. [	NPR Date: Contractor's Vendo 0 ]If line 5, cc number of tim	or Code: Jumn 1 is 4: En Nes reopened = 0:	4 ter -9.
PART I	- CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMII	NI STRATOR (	R PROVIDER(S)			
MI SREPI ADMI NI S PROVI DI	RESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAIN STRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL D OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECT STRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	IED IN THIS	COST REPORT MAY BE THERMORE, IF SERVICE	S IDENTIFIED IN T	HIS REPORT WERE	
	CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINIST	RATOR OF PR	ROVI DER(S)			
	I HEREBY CERTIFY that I have read the above certifical electronically filed or manually submitted cost report Statement of Revenue and Expenses prepared by DEACON beginning 10/01/2020 and ending 09/30/2021 and to the are true, correct, complete and prepared from the boo applicable instructions, except as noted. I further of regarding the provision of health care services, and provided in compliance with such laws and regulations	rt and subm ESS GIBSON e best of m oks and rec certify tha that the s	nitted cost report an (15-1319) for the ny knowledge and beli cords of the provider nt I am familiar with	nd the Balance She cost reporting pe ef, this report a in accordance wi the laws and reg	eet and eriod and statement th gulations	
S	IGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		ELECTRONI C		
	1	2	SIGN	ATURE STATEMENT		
1	Claudia Eisenmann	Y	I have read and agrees statement. I certify signature on this ce	y that I intend m	y el ectroni c	1

2	Signatory Printed Name	Claudia Eisenmann		2
3	Signatory Title	CEO		3
4	Date	(Dated when report is electronica		4

binding equivalent of my original signature.

			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	7, 789	-1, 196, 192	0	-4, 370	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	432, 251	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		8, 634		0	10.00
10.01	RURAL HEALTH CLINIC II	0		11, 843		0	10.01
200.00	Total	0	440, 040	-1, 175, 715	0	-4, 370	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 TAL AND HOSPITAL HEALTH CARE COMPLEX	DEACONESS		ler CCN		Peri od:		of For Workshe Part I		
						From 10/01/ To 09/30/	2021	Date/Ti		
	1.00	2.00		3.00		4	1.00	2/28/20	22 10:	<u>06 ai</u>
	Hospital and Hospital Health Care Co	mplex Address:								
00	Street: 1800 SHERMAN DRIVE	PO Box:	Zin Cod	a. 17(7)	Count					1.
00	City: PRINCETON	State: IN Component Name	Zip Cod CCN	CBSA		y: GIBSON Date	Pavme	nt Syst	em (P.	2.
			Number	Numbe		Certified		0, or		
		1.00	0.00		1.00	<b></b>	V	XVIII	XIX	-
	Hospital and Hospital-Based Componer	1.00 1.dentification	2.00	3.00	4.00	5.00	6.00	7.00	8.00	-
00	Hospi tal	DEACONESS GIBSON	151319	9991	5 1	12/16/2003	N	0	0	3.
00	Subprovider - IPF									4.
)0 )0	Subprovider - IRF Subprovider - (Other)									5.
00	Swing Beds - SNF	GIBSON GENERAL SWING	15Z319	9991	ō	12/16/2003	N	0	Ν	7.
		BED								
00	Swing Beds - NF									8.
00 00	Hospital-Based SNF Hospital-Based NF									10.
00	Hospital -Based OLTC									11.
00	Hospital-Based HHA	GIBSON HOME HEALTH	157445	9991	ō	10/19/1995	Ν	P	Ν	12.
00 00	Separately Certified ASC Hospital-Based Hospice									13.
00		GIBSON GENERAL FAMILY	158524	9991	5	09/11/2017	Ν	0	0	15.
		MEDICINE FORT			_					
01	Hospital-Based Health Clinic - RHC	GIBSON GENERAL FAMILY MEDICINE- 510	158553	9991	5	05/29/2019	N	0	0	15.
00	Hospital-Based Health Clinic - FQHC	MEDICINE- 510								16.
00	Hospital-Based (CMHC) I									17.
00	Renal Dialysis Other									18.
00	other			I		From:		То	:	19.
						1.00		2.0		1
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					10/01/20	020	09/30/	2021	20.
00	Type of control (see this fuctions)					2				21.
					1.00	2.00		3. C	0	1
~~	Inpatient PPS Information			-	N	N				
00	Does this facility qualify and is it disproportionate share hospital adju				Ν	N				22.
	§412.106? In column 1, enter "Y" fo	r yes or "N" for no. Is	this							
	facility subject to 42 CFR Section §		endment							
01	hospital?) In column 2, enter "Y" fo Did this hospital receive interim ur	5	ts for th	is	Ν	N				22.
01	cost reporting period? Enter in colu				N					22.
	the portion of the cost reporting pe	riod occurring prior to	October	1.						
	Enter in column 2, "Y" for yes or "N reporting period occurring on or aft									
02	Is this a newly merged hospital that				Ν	N				22.
	payments to be determined at cost re									
	Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob									
		e cost reporting period	on or an							
	or "N" for no, for the portion of the October 1.							N		22.
03	or "N" for no, for the portion of th October 1. Did this hospital receive a geograph	ic reclassification fro	m urban t		Ν	N				
03	or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar	ic reclassification fro ds for delineating stat	m urban t istical a	reas	Ν	N				
03	or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob	m urban t istical a "N" for er 1. Ent	reas no	Ν	N				
03	or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in o for the portion of the cost reportin in column 2, "Y" for yes or "N" for	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t	m urban t istical a "N" for er 1. Ent he cost	reas no	Ν	N				
03	or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst	m urban t istical a "N" for er 1. Ent he cost ructions)	reas no er	Ν	N				
03	or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in o for the portion of the cost reportin in column 2, "Y" for yes or "N" for	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4	m urban t istical a "N" for er 1. Ent he cost ructions) 99 beds (	reas no er as	Ν	N				
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	or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in of for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob	m urban t istical a "N" for er 1. Ent he cost ructions) 99 beds ( 3, "Y" f m urban t stical ar r "N" for er 1. Ent	reas no er as or o eas no				N		22.
	or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t	m urban t istical a "N" for er 1. Ent he cost ructions) 99 beds ( 3, "Y" f m urban t stical ar r "N" for er 1. Ent he cost	reas no er as or o eas no				Ν		22.
	or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst	m urban t istical a "N" for er 1. Ent he cost ructions) 99 beds ( 3, "Y" f m urban t stical ar r "N" for er 1. Ent he cost ructions)	reas no er as or o eas no er				Ν		22.
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SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ACONESS GIB	Provider CC	N: 15-1319	Peri od:		Worksh	eet S-2	
				From 10/0 To 09/3	01/2020 0/2021	Part I Date/T 2/28/2	ime Pre 022 10:	eparec
	In-State Medicaid paid days	ln-State Medicaid eligible unpaid	Out-of State Medicaid paid days	Out-of State Medicaid eligible	Medicai HMO day	ys Me	ther di cai d days	
	1.00	days	2.00	unpai d	E 00	_	<u> </u>	-
.00 If this provider is an IPPS hospital, enter the	1.00	2.00	3.00	4.00	5.00	0	5.00 0	24.0
<ul> <li>in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.</li> <li>O0 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</li> </ul>	0	0		0		0		25.0
HMO paid and eligible but unpaid days in column 5.					ural S I			_
.00 Enter your standard geographic classification (not wa		at the be	ginning of	the 1.	2	2.	00	26.0
<ul> <li>cost reporting period. Enter "1" for urban or "2" for</li> <li>.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</li> </ul>	age) status r "2" for r ication in	ural. If a column 2.	ppl i cabl e,		2			27.0
.00   f this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods S	CH status i		0			35.0
				Begi n 1.		Endi 2.		-
.00 Enter applicable beginning and ending dates of SCH st		cript line	36 for num	ber				36.
of periods in excess of one and enter subsequent date .00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period. .01 Is this hospital a former MDH that is eligible for th	r the numbe			us	0			37. 37.
accordance with FY 2016 OPPS final rule? Enter "Y" for instructions) .00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of	or yes or " s of MDH st	N" for no. atus. If li	(see ine 37 is					38.
enter subsequent dates.							<i>.</i> .	
				Y/ 1.1		<u> </u>		-
						N		39.
.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 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	), (íi), or the mileage ii)? Enter	(iii)? En requirement in column :	ter in colu nts in 2 "Y" for y	mn es				
<ul> <li>hospitals in accordance with 42 CFR §412.101(b)(2)(i)</li> <li>1 "Y" for yes or "N" for no. Does the facility meet faccordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)</li> <li>.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob</li> </ul>	), (ii), or the mileage ii)? Enter n adjustmer per 1. Ente	(iii)? En requirement in column : t? Enter "' r "Y" for ;	ter in colu nts in 2 "Y" for y Y" for yes	mn es or N	I	٩	l	40.0
<pre>hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet faccordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions) .00 Is this hospital subject to the HAC program reduction</pre>	), (ii), or the mileage ii)? Enter n adjustmer per 1. Ente	(iii)? En requirement in column : t? Enter "' r "Y" for ;	ter in colu nts in 2 "Y" for y Y" for yes	mn es or N	I	XVIII	XI X 3 00	40.
<ul> <li>hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet faccordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions)</li> <li>.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.</li> <li>Prospective Payment System (PPS)-Capital</li> </ul>	), (İi), or the mileage ii)? Enter n adjustmer ber 1. Ente . (see inst	(iii)? En requirement in column : t? Enter "' r "Y" for y ructions)	ter in colu nts in 2 "Y" for y Y" for yes yes or "N"	mn es or N for	V 1.00	XVIII 2.00	3.00	
<ul> <li>hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet faccordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions)</li> <li>.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October no in column 2, for discharges on or after October 1.</li> <li>.00 Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)</li> </ul>	), (İi), or the mileage ii)? Enter n adjustmer per 1. Ente . (see inst nt for disp	roportiona	ter in colu nts in 2 "Y" for y Y" for yes yes or "N" te share in	mn es for accordance	V 1.00 e N	N XVIII 2.00 N	3.00	45.
<ul> <li>hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet faccordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions)</li> <li>.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.</li> <li>.00 Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)</li> <li>.00 Is this facility eligible for additional payment excorpursuant to 42 CFR §412.348(f)? If yes, complete Wkst</li> </ul>	), (İi), or the mileage i)? Enter n adjustmer per 1. Ente . (see inst . (see inst . nt for disp	(iii)? En requirement in column t? Enter "' r "Y" for ructions) roportiona extraordin	ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums	mn es or M for accordance	V 1.00	XVIII 2.00	3.00	40. 45. 46.
<ul> <li>hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet faccordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions)</li> <li>.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.</li> <li>.00 Prospective Payment System (PPS)-Capital</li> <li>.00 Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)</li> <li>.00 Is this facility eligible for additional payment exce</li> </ul>	), (ii), or the mileage ii)? Enter n adjustmer per 1. Ente . (see inst . (see inst nt for disp eption for t. L, Pt. I capital? E	roportiona extraordina in and Wks in column in column it? Enter "' for "Y" for ructions)	ter in colu nts in 2 "Y" for y Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N	mn es or N for accordance tances I through	V 1.00 e N	N XVIII 2.00 N	3.00	45.
<ul> <li>hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions)</li> <li>.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October 1.</li> <li>Prospective Payment System (PPS)-Capital</li> <li>.00 Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions)</li> <li>.00 Is this facility eligible for additional payment excer pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.</li> <li>.00 Is this a new hospital under 42 CFR §412.300(b) PPS of Is this a new hospital under 42 CFR §412.300(b) PPS of Is this a hospitals</li> <li>.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME priver, and are you are impacted by CR 11642 (or applic)</li> </ul>	), (ii), or the mileage ii)? Enter n adjustmen per 1. Enter . (see inst . (see inst . (see inst . Enter isp approved G e to column rograms in cable CRs)	(iii)? En requirement in column r"Y" for ructions) roportiona extraordina II and Wks inter "Y for Y" for yes ME programa 1 is "Y", the prior	ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen	mn es or for accordance tances I through " for no. no. " for yes o hospital ultimate	I V 1.00 N N N N N N N N N	N XVIIII 2.00 N N N	3.00 N N	45. 46. 47. 48.
<ul> <li>hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions)</li> <li>.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October 1.</li> <li>Prospective Payment System (PPS)-Capital</li> <li>.00 Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions)</li> <li>.00 Is this facility eligible for additional payment excer pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.</li> <li>.00 Is this a new hospital under 42 CFR §412.300(b) PPS of Is this a new hospital under 42 CFR §412.300(b) PPS of Is this a hospitals</li> <li>.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pr year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col If line 56 is yes, is this the first cost reporting pr 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 "N"</li> </ul>	), (ii), or the mileage ii)? Enter n adjustmen ber 1. Enter . (see inst . (see inst . (see inst . Enter is approved G e to column rograms in cable CRs) lumn 2. beriod duri r yes or "N th of this Y", complet	<pre>(iii)? En a requirement in column a at? Enter "' ar "Y" for ructions) roportiona extraordina II and Wks inter "Y for Y" for yes ME program 1 is "Y", the prior y MA direct of mg which re " for no in cost repor e Workshee</pre>	ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period	mn es or for accordance tances I through " for no. no. " for yes o hospital ultimate reduction? approved If column ? Enter ")	I V 1.00 N N N N N N N N 1	N XVIIII 2.00 N N N	3.00 N N	45. 46. 47. 48. 56.
<ul> <li>hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions)</li> <li>.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October 1.</li> <li>Prospective Payment System (PPS)-Capital</li> <li>.00 Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)</li> <li>.00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.</li> <li>.00 Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals</li> <li>.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pr year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col On 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 montained to the first cost reporting p</li> </ul>	), (ii), or the mileage ii)? Enter n adjustmen ber 1. Enter . (see inst . (see inst . (see inst . Enter . L, Pt. I capital? E t? Enter " approved C e to columr rograms in cable CRS) lumn 2. beriod duri r yes or "N th of this Y", complet I, if appli bursement f	(iii)? En requirement in column t? Enter "' r" "Y" for ructions) roportiona extraordina II and Wks nter "Y for Y" for yes ME program 1 is "Y", the prior MA direct ng which re "for no in cost repor e Workshee cable. "or physicia	ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period t E-4. If c	mn es or for for accordance tances 1 through " for no. no. " for yes of hospi tal ul ti mate reducti on? approved 1 f col umn ? Enter " \ ol umn 2 i s	I V 1.00 N N N N N N N N 1	N XVIIII 2.00 N N N	3.00 N N	45. 46. 47.

ealth Financial Systems DE/ HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D/	ACONESS ATA	Provi der C		Period: From 10/01/2020	u of Form CMS-2 Worksheet S-2 Part I	
				To 09/30/2021	Date/Time Pre 2/28/2022 10:	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
0.00 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 co is "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in col	.85? (s Lumn 1. CR) NAHE	see If column 1	N			60.00
	Y/N	IME	Direct GME	I ME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
<ul> <li>Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> <li>Enter the average number of unweighted primary care</li> </ul>	N			0.00	0.00	61.00 61.01
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						
1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
b1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Pro	gram Name	Program Code	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
51.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
1.20 Of the FTEs in Line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Se				ni od for which		(0.00
2.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instru		i in this cost	reporting pe	riod for which	0.00	62.00
2.01 Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pro	a Teachi gram. (s	ee instructio		o your hospital	0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovid 03.00 Has your facility trained residents in nonprovider s "Y" for yes or "N" for no in column 1. If yes, compl	ettings	during this o			N	63.00

alth Financial Systems ISPITAL AND HOSPITAL HEALTH CARE COMPL		ACONESS GIBSON ATA Provider CO		eri od:	u of Form CMS-2 Worksheet S-2	
			Тс	rom 10/01/2020 09/30/2021	Part I Date/Time Pre 2/28/2022 10:	pared: <u>06 am</u>
			Unweighted	Unweighted	Ratio (col.	
			FTEs Nonprovider	FTEs in Hospital	1/ (col . 1 + col . 2))	
			Si te 1.00	2.00	3.00	-
Section 5504 of the ACA Base Yea	r FTE Residents in N	lonprovider Settings-				
period that begins on or after J			-		0.000000	
.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	per of unweighted no tations occurring in number of unweighte ur hospital. Enter i	n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.0
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
	5		FTËs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
_			Si te			-
.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	Unwei ghted	Ratio (col.	
			FTEs Nonprovider Site	FTEs in Hospital	1/ (col . 1 + col . 2))	
Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Setting	1.00 psEffective f	<u>2.00</u> or cost report	3.00 ing periods	
beginning on or after July 1, 20 b. 00 Enter in column 1 the number of	10					
FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	00.0
	Program Name	Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 +	
			Nonprovi der	Hospi tal	col. 4))	
	1.00	2.00	Si te 3. 00	4.00	5.00	-
.00 Enter in column 1, the program	1.00	2.00	0.00	4.00		67.0
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						

Heal th	Financial Systems DEACC	DNESS GIBSON	In Lie	u of Form	n CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Period: From 10/01/2020 To 09/30/2021		me Pre	pared:
				2/28/20		06 am
	Inpatient Psychiatric Facility PPS			0 2.00	3.00	
70.00	ls this facility an Inpatient Psychiatric Facility (IPA Enter "Y" for yes or "N" for no.	F), or does it contain an IPF su	bprovider? N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an a recent cost report filed on or before November 15, 200- 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facili program in accordance with 42 CFR 412.424 (d)(1)(iii)(I Column 3: If column 2 is Y, indicate which program year (see instructions)	4? Enter "Y" for yes or "N" for ity train residents in a new tea D)? Enter "Y" for yes or "N" for	no. (see chi ng no.		0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility	(IRF), or does it contain an IRF	N			75.00
76 00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an a	approved GME teaching program in	the most		0	76.00
10100	recent cost reporting period ending on or before Novemb no. Column 2: Did this facility train residents in a ne CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" fo indicate which program year began during this cost repo	ber 15, 2004? Enter "Y" for yes ew teaching program in accordanc or no. Column 3: If column 2 is	or "N" for e with 42 Y,		Ū	
				1.0	0	-
	Long Term Care Hospital PPS				0	
80. 00 81. 00	Is this a long term care hospital (LTCH)? Enter "Y" for Is this a LTCH co-located within another hospital for p		g period? Enter	N N		80.00 81.00
	"Y" for yes and "N" for no. TEFRA Providers					
	Is this a new hospital under 42 CFR Section §413.40(f) Did this facility establish a new Other subprovider (ex §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 ho 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ospital classified under section		N		87.00
			V 1.00	XI X 2. 0		
00.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient ho	popital convious? Enter "V" for	N	Y	0	90.00
	yes or "N" for no in the applicable column.					
	Is this hospital reimbursed for title V and/or XIX thro full or in part? Enter "Y" for yes or "N" for no in the	e applicable column.	N	Y		91.00
	Are title XIX NF patients occupying title XVIII SNF bea instructions) Enter "Y" for yes or "N" for no in the approximation of the second second second second second se	pplicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purp "Y" for yes or "N" for no in the applicable column.	poses of title V and XIX? Enter	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for applicable column.	yes, and "N" for no in the	Ν	N		94.00
	If line 94 is "Y", enter the reduction percentage in the Does title V or XIX reduce operating cost? Enter "Y" for applicable column.		0. 00 N	0. 0 N	0	95.00 96.00
	If line 96 is "Y", enter the reduction percentage in th Does title V or XIX follow Medicare (title XVIII) for stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter	the interns and residents post	0. 00 Y	0. 0 Y	0	97.00 98.00
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for C, Pt. I? Enter "Y" for yes or "N" for no in column 1 t title XIX.	1 5 5		Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for t bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for for title V, and in column 2 for title XIX.		Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a reimbursed 101% of inpatient services cost? Enter "Y" 1			N		98.03
98.04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a outpatient services cost? Enter "Y" for yes or "N" for		N	N		98.04
98.05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and a Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no			Y		98.05
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when Pts. I through IV? Enter "Y" for yes or "N" for no in a column 2 for title XIX.		Y	Y		98.06
105 00	Rural Providers			I I		105 00
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the	e all-inclusive method of paymen	t N			105.00 106.00
107.00	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible 1	for cost reimbursement for I&R	Ν			107.00
	training programs? Enter "Y" for yes or "N" for no in o Column 2: If column 1 is Y and line 70 or line 75 is Y approved medical education program in the CAH's exclude	column 1. (see instructions) Y, do you train l&Rs in an ed IPF and/or IRF unit(s)?				
	Enter "Y" for yes or "N" for no in column 2. (see ins	tructions)		1		1

Health Financial Systems DEACONESS (	GLBSON		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	F	Period: From 10/01/2020 To 09/30/2021	Worksheet S- Part I Date/Time Pr 2/28/2022 10	epared:
			V	XIX	
108.00 Is this a rural hospital qualifying for an exception to the	CRNA fee sche	edul e? See 42	1.00 N	2.00	108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
-	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	_
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	N	N	N	109.00
110.00 Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes or	r "N" for no.	f yes,	1.00 N	110.00
			1.00	2.00	-
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	st reporting lumn 1 is Y, ticipating ir	period? Enter enter the n column 2.	N	2.00	111.00
		1.00	2.00	3.00	_
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in th demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable.	period? "Y", enter e	N			112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N			0115.00
in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care ( psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub.15-1, chapter 22, §2208.1.	, or E only) 3" percent includes s) based on				
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.00
117.00 Is this facility legally-required to carry malpractice insur	ance? Enter	Y			117.00
"Y" for yes or "N" for no. 118.00 is the malpractice insurance a claims-made or occurrence pol if the policy is claim-made. Enter 2 if the policy is occurr			1		118.00
In the porrey is cranin-made. Enter 2 in the porrey is occur	ence.	Premi ums	Losses 2. 00	I nsurance	
118.01 List amounts of malpractice premiums and paid losses:		149, 34			0118.01
			1.00	2.00	_
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.			Y	2.00	118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendmen	column 1, "۱ alifies for 1	Y" for yes or the Outpatient	N	Ν	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	ntable device	es charged to	Y		121.00
122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			N		122.00
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" fo	r yes and "N'	'for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en	ter the certi	fication date			126.00
in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, ent					127.00
in column 1 and termination date, if applicable, in column 2 128.00  f this is a Medicare certified liver transplant center, ent					127.00
in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, enter			n l		128.00
column 1 and termination date, if applicable, in column 2.					

	EX IDENTIFICATION DATA	Provider CC	CN: 15-1319	Peri od:	ieu of Form CMS Worksheet S-	
				From 10/01/20 To 09/30/20		repared ):06 am
				1.00	2.00	_
30.00 f this is a Medicare certified p	ancreas transplant cent	ter, enter the cer	ti fi cati on	1.00	2.00	130.0
date in column 1 and termination 31.00If this is a Medicare certified i	ntestinal transplant ce	enter, enter the c	erti fi cati or	1		131.0
date in column 1 and termination 22.00 If this is a Medicare certified i in column 1 and termination date,	slet transplant center,	enter the certif	ication date	e		132. (
<ul> <li>33.00 Removed and reserved</li> <li>34.00 If this is an organ procurement o and termination date, if applicab</li> </ul>	rganization (OPO), ente		in column 1			133. ( 134. (
All Providers 10.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th	"N" for no in column 1. <u>e home office chain num</u>	If yes, and home mber. (see instruc	office cost		HB0778	140. (
<u> </u>	in organization, enter		ugh 143 the	3.00 name and addre	ess of the home	
11. 00 Name: DEACONESS HEALTH SYSTEM	Contractor's Name	WI SCONSI N PHYSI C SERVI CES	I ANS Contrac	tor's Number: 0	3101	141. (
42.00Street:600 MARY STREET 43.00City: EVANSVILLE	PO Box: State:	IN	Zip Code	A <sup>-</sup>	7710	142.0 143.0
		- IV		5. 4		143.0
4.00 Are provider based physicians' co	sts included in Workshe	et A?			1.00 Y	144.
						_
5.00 If costs for renal services are c inpatient services only? Enter "Y no, does the dialysis facility in	" for yes or "N" for no clude Medicare utilizat	o in column 1. If	column 1 is	1.00	2.00	145.
period? Enter "Y" for yes or "N" 6.00Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	gy changed from the pre n column 1. (See CMS Pu			f		146.
					1.00	-
7.00 Was there a change in the statist	ical basis? Enter "Y" f	for yes or "N" for	no.		N	147.
8.00Was there a change in the order o 9.00Was there a change to the simplif				or no.	N	
					N	
		Part A	Part B	Title V	Title XIX	
Does this facility contain a prov	ider that qualifies for	Part A 1.00	2.00	Title V 3.00	Title XIX 4.00	
or charges? Enter "Y" for yes or		Part A 1.00 an exemption fro mponent for Part A	2.00 m the appli and Part B	Title V 3.00 cation of the l . (See 42 CFR s	Title XIX           4.00           ower of costs           6413.13)	149.
or charges? Enter "Y" for yes or 5.00Hospital		Part A 1.00 r an exemption fro	2.00 m the appli	Title V 3.00 cation of the I	Title XIX 4.00 ower of costs	149.  155.
or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF		Part A 1.00 r an exemption fro mponent for Part A N	2.00 m the appli and Part B N	Title V 3.00 cation of the I . (See 42 CFR s N	Title XIX           4.00           ower of costs           6413.13)	149. 155. 156. 157.
or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER		Part A 1.00 an exemption fro mponent for Part A N N N	2.00 m the appli and Part B N N N	Title V 3.00 cation of the I . (See 42 CFR 9 N N N	Title XIX 4.00 ower of costs \$413.13) N N N	149. 155. 156. 157. 158.
or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF		Part A 1.00 an exemption fro mponent for Part A N N	2.00 m the appli and Part B N N N	Title V 3.00 cation of the I . (See 42 CFR § N N	Title XIX           4.00           ower of costs           \$413.13)           N           N           N           N           N           N           N	149. 155. 156. 157. 158. 159.
or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY		Part A 1.00 an exemption from mponent for Part A N N N N	2.00 m the appli and Part B N N N	Title V 3.00 cation of the I . (See 42 CFR 9 N N N N	Title XIX 4.00 ower of costs \$413.13) N N N	149. 155. 156. 157. 158. 159. 160.
or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY		Part A 1.00 an exemption from mponent for Part A N N N N	2.00 m the appli and Part B N N N N N	Title V 3.00 cation of the L . (See 42 CFR 4 N N N N N N	Title XIX 4.00 ower of costs 3413.13) N N N N N N N	149. 155. 156. 157. 158. 159. 160.
or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multic	"N" for no for each com	Part A 1.00 an exemption fro mponent for Part A N N N N N	2.00 m the appli and Part B N N N N N N N	Title V 3.00 cation of the I . (See 42 CFR 9 N N N N N N N	Title XIX           4.00           ower of costs           3413.13)           N           N           N           N           N           N           N           N           N           N           N           N	149. 155. 156. 157. 158. 159. 160. 161. -
or charges? Enter "Y" for yes or 5.00 Hospi tal 6.00 Subprovi der - I PF 7.00 Subprovi der - I RF 8.00 SUBPROVI DER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Mul ti campus	"N" for no for each com	Part A 1.00 an exemption fro mponent for Part A N N N N N	2.00 m the appli and Part B N N N N N N uses in diff	Title V 3.00 cation of the I . (See 42 CFR 9 N N N N N N N	Title XIX 4.00 ower of costs 3413.13) N N N N N N N N N N N N N	149. 155. 156. 157. 158. 159. 160. 161. -
or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	"N" for no for each com ampus hospital that has	Part A 1.00 r an exemption fro mponent for Part A N N N N N S one or more camp	2.00 m the appli and Part B N N N N N N N	Title V 3.00 cation of the L . (See 42 CFR 9 N N N N N N N S Ferent CBSAs?	Title XIX           4.00           ower of costs           \$413.13)           N           N           N           N           N           N           N           N           N           N           N           N           N           N           FTE/Campus           5.00	149. 155. 156. 157. 158. 159. 160. 161. 165. 165.
or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	"N" for no for each com ampus hospital that has Name	Part A 1.00 r an exemption fro mponent for Part A N N N N N Sone or more camp County	2.00 m the appli and Part B N N N N N N N State Z	Title V       3.00       cation of the I       . (See 42 CFR 9       N       N       N       N       N       N       N       N       Second CBSAs?	Title XIX           4.00           ower of costs           \$413.13)           N           N           N           N           N           N           N           N           N           N           N           N           N           N           FTE/Campus           5.00	148. ( 149. ( 155. ( 156. ( 157. ( 158. ( 157. ( 158. ( 157. ( 159. ( 160. ( 161. ( 165. ( 165. ( 165. ( 165. ( 165. ( 166. ( ) 00 ( 166. (
or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	"N" for no for each com ampus hospital that has Name	Part A 1.00 r an exemption fro mponent for Part A N N N N N Sone or more camp County	2.00 m the appli and Part B N N N N N N N State Z	Title V       3.00       cation of the I       . (See 42 CFR 9       N       N       N       N       N       N       N       N       Second CBSAs?	Title XIX 4.00 ower of costs 3413.13) N N N N N N N N N N N N N	149. 155. 156. 157. 158. 159. 160. 161. 161. 165. 165.
or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 7.00 Is this provider a meaningful use	<pre>"N" for no for each com ampus hospital that has Name 0 0 T) incentive in the Ame r under §1886(n)? Ente</pre>	Part A 1.00 r an exemption from mponent for Part A N N N N N Sone or more camp County 1.00 Part A N N N N N N N N N N N N N	2.00 m the applin and Part B N N N N N N N uses in diff State Z 2.00 d Reinvestm "N" for no.	Title V 3.00 Cation of the l (See 42 CFR 9 N N N N N N N N N N N N N	Title XIX           4.00           ower of costs           \$413.13)           N           N           N           N           N           N           N           N           N           N           N           N           N           N           FTE/Campus           5.00	149. 155. 156. 157. 158. 159. 160. 161. 165. 00 166.
or charges? Enter "Y" for yes or 55.00 Hospital 66.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC 55.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful use 88.00 If this provider is a CAH (line 1 reasonable cost incurred for the	<pre>"N" for no for each com ampus hospital that has Name 0 T) incentive in the Ame r under §1886(n)? Ente 05 is "Y") and is a mea HIT assets (see instruct)</pre>	Part A 1.00 an exemption from monent for Part A N N N N N N N N N N N N N	2.00 m the applia and Part B N N N N N uses in diff State Z 2.00 d Reinvestm "N" for no. e 167 is "Y"	Title V 3.00 Cation of the I (See 42 CFR 9 N N N N N S Ferent CBSAs? ip Code CBSA 3.00 4.00 ent Act '), enter the	Title XIX 4.00 ower of costs 3413.13) N N N N N N N N N N N N N	149. 155. 156. 157. 158. 159. 160. 161. 165. 00 166. 00 166. 167. 168.
or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line 1)	<pre>"N" for no for each com ampus hospital that has Name 0 T) incentive in the Ame r under §1886(n)? Ente 05 is "Y") and is a mea HIT assets (see instruction not a meaningful user,</pre>	Part A 1.00 an exemption from monent for Part A N N N N N N N N N N N N N	2.00 m the applid and Part B N N N N uses in diff State Z 2.00 d Reinvestm "N" for no. e 167 is "Y" r qualify for	Title V 3.00 Cation of the I (See 42 CFR 9 N N N N N N S Ferent CBSAs? ip Code CBSA 3.00 4.00 ent Act '), enter the prahardship	Title XIX 4.00 ower of costs 3413.13) N N N N N N N N N N N N N	149. 155. 156. 157. 158. 159. 160. 161. 165. 0 166. 165. 165.

Health Financial Systems	DEACONESS G	I BSON	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA		Period:	Worksheet S-2	2
			From 10/01/2020		
			To 09/30/2021	Date/Time Pro 2/28/2022 10:	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR be period respectively (mm/dd/yyyy)	ginning date and ending da	ate for the reporting			170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provi	der have any days for indi	viduals enrolled in	N	(	0171.00
section 1876 Medicare cost plans re	ported on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in colum	n 1. lf column 1 is yes, e	enter the number of section	on		
1876 Medicare days in column 2. (se	e instructions)				

	Financial Systems DEACONESS		<u></u>		u of Form CMS	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1319	Period: From 10/01/2020 To 09/30/2021	Worksheet S- Part II Date/Time Pi 2/28/2022 10	repared
				Y/N	Date	<u>. 00 all</u>
	r			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format.	lforall NO re	esponses. Ent	ter all dates in	the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					_
1.00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a			5) Y	09/30/2020	1.
			Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colur voluntary or "I" for involuntary.		N			2.
3. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					- · ·
4.00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" to or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.(
5.00	Are the cost report total expenses and total revenues diffe		N			5.
	those on the filed financial statements? If yes, submit red	conciliation.		Y/N	Legal Oper.	
				1.00	2.00	-
	Approved Educational Activities					
5.00	Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?		s the provide	er N		6.
7.00 3.00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during th	ne N		7. 8.
9.00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	n N		9.
10.00	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		the current	Ν		10.
11.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	l & R in an Ap	proved	N	Y/N	11.
					1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Y N	12. 13.
14.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	fyes, see in	nstructions.	N	14.
5.00	Did total beds available change from the prior cost report	<u>v</u> 1	yes, see ins t A		N t B	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
16.00	<u>PS&amp;R Data</u> Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	Y	12/29/2021	Y	12/29/2021	16.
7.00	instructions) 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	Ν		Ν		18.
19.00	but are not included on the PS&R Report used to file this 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 information? If yes, see instructions.	Ν		Ν		19.

djustments made to PS&R	F		Period: From 10/01/2020 To 09/30/2021	Part II Date/Time P 2/28/2022 1		
	Descr	iption	Y/N	Y/N		
		0	1.00	3.00		
the other adjustments:			Ν	Ν	20.00	
	Y/N	Date	Y/N	Date		
	1.00	2.00	3.00	4.00		
ly using the provider's ns	N		N		21.00	
				1.00		
D TEFRA HOSPITALS ONLY (EX	CEDT CULLIDDENS			1.00	_	
J TELKA HUSFITALS UNET (LA	CLET CHILDRENS	IUSFITALS)			_	
dicare purposes? If yes, s	ee instructions			N	22.00	
dicare depreciation expens			ing the cost	N	22.00	
	e uue to appiai	sais liaue uui	The cost	IN	23.00	
nstructions. ts to existing leases ente	red into during	this cost re	porting period?	Ν	24.00	
If yes, see instructions 00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see						
instructions.						
) Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see						
		51	J	Ν	26.00	
on policy changed during t	he cost reporti	ng period? If	yes, submit	N	27.00	
			-			
00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting						
period? If yes, see instructions.						
0.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)						
treated as a funded depreciation account? If yes, see instructions						
0.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see						
instructions.						
31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.						
					_	
occurred in patient care s	orvi cos furni sh	od through co	ntractual	N	32.00	
services? If yes, see inst		eu thiough co	inti actual	IN	32.00	
uirements of Sec. 2135.2 a		na to competi	tive bidding? If	N	33.00	
	pprica per tarm	ing to competi	tive broaring: II	i N	33.00	
rovider facility under an	arrangement wit	h provider-ba	sed physicians?	Y	34.00	
	5	P				
ew agreements or amended e	xisting agreeme	nts with the	provi der-based	Ν	35.00	
rting period? If yes, see	instructions.					
			Y/N	Date		
			1.00	2.00		
on the cost report?			Y		36.00	
ffice cost statement been	prepared by the	home office?	Y		37.00	
		Email and a company			00.00	
cal year end of the home o			N		38.00	
column 2 the fiscal year e			N		39.00	
ider render services to ot	пет спати сопро	nents: IT yes	, N		39.00	
ider render services to th	e home office?	lf ves see	N		40.00	
		11 903, 300	IN		-0.00	
	1.	00	2.	00		
formation	ALICTIN		FI SHER		41.00	
	AUSTIN					
and the title/position	AUSTIN					
and the title/position r in columns 1, 2, and 3,					1 10 00	
and the title/position	BLUE & CO.				42.00	
and the title/position r in columns 1, 2, and 3,			AFI SHER@BLUEANI		42.00	
	nformation	nformation e and the title/position   AUSTIN	nformation	nformation e and the title/position AUSTIN FISHER	nformation e and the title/position AUSTIN FISHER er in columns 1, 2, and 3,	

Health Financial Systems DEACONE	SS GI BSON	In Lie	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1319	Peri od:	Worksheet S-2			
		From 10/01/2020 To 09/30/2021		pared: 06 am		
	3.00					
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the title/position	MANAGER			41.00		
held by the cost report preparer in columns 1, 2, and 3,						
respectively.						
42.00 Enter the employer/company name of the cost report				42.00		
preparer.						
43.00 Enter the telephone number and email address of the cost				43.00		
report preparer in columns 1 and 2, respectively.						

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	DEACONESS	Provider C	CN: 15 1210	Peri od:	u of Form CMS-2 Worksheet S-3	
HUSPI I	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN. 13-1319	From 10/01/2020		
					To 09/30/2021	Date/Time Pre	
	· · · · · · · · · · · · · · · · · · ·					2/28/2022 10:	<u>06 am</u>
						I/P Days /	
						0/P Visits /	
	Component	Worksheet A	No. of Beds	Ded Devre	CAH Hours	Trips Title V	
	Component	Line Number	NO. OI BEUS	Bed Days Available	CAH HOULS	ntie v	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	2:00			0.00	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		20	7,3	00 18, 792. 00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	5	1, 8	25 504.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY					_	13.00
14.00	Total (see instructions)		25	9, 1	25 19, 296. 00	0	
15.00	CAH visits					0	
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00							18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY OTHER LONG TERM CARE						20.00
21.00	HOME HEALTH AGENCY	101.00				0	
22.00	AMBULATORY SURGICAL CENTER (D. P. )	101.00				0	22.00
24.00	HOSPICE						23.00
24.10	HOSPICE (non-distinct part)	30.00					24.00
25.00	CMHC - CMHC	30.00					24.10
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25			-	27.00
28.00	Observation Bed Days					0	
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						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

SPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	DEACONESS ( CAL DATA	Provider CC		Period: From 10/01/2020 To 09/30/2021		
					2/28/2022 10:	
	I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
Component	Title XVIII	Title XIX	Total All	Total Interns		
	( 00	7.00	Patients 8.00	& Residents 9.00	Payrol I 10.00	
00 Hospital Adults & Peds. (columns 5, 6, 7 and	6.00	7.00			10.00	1.
8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	010	10	70			
for the portion of LDP room available beds)						
00 HMO and other (see instructions)	169	89				2.
00 HMO I PF Subprovi der	0	0				3.
00 HMO IRF Subprovider	0	0				4.
00 Hospital Adults & Peds. Swing Bed SNF	930	0	93	0		5
00 Hospital Adults & Peds. Swing Bed NF		0	72	7		6.
00 Total Adults and Peds. (exclude observation	1, 245	10	2,44	0		7
beds) (see instructions)						
00 I NTENSI VE CARE UNI T	8	0	2	1		8
00 CORONARY CARE UNIT						9
. 00 BURN I NTENSI VE CARE UNI T						10
. 00 SURGICAL INTENSIVE CARE UNIT . 00 OTHER SPECIAL CARE (SPECIFY)						11
. 00 OTHER SPECIAL CARE (SPECIFY) . 00 NURSERY						13
. 00 Total (see instructions)	1, 253	10	2,46	1 0.00	261.33	
5.00 CAH visits	0	0		0	201.00	15
. OO SUBPROVIDER - IPF		-		-		16
. 00 SUBPROVIDER - IRF						17
8. 00 SUBPROVI DER						18
. 00 SKILLED NURSING FACILITY						19
. OO NURSING FACILITY						20
. OO OTHER LONG TERM CARE						21
. OO HOME HEALTH AGENCY	4, 443	317	6, 16	7 0.00	9. 27	
. 00 AMBULATORY SURGICAL CENTER (D. P. )						23
						24
. 10 HOSPICE (non-distinct part)				0		24
. 00 CMHC - CMHC . 00 RURAL HEALTH CLINIC	263	497	2, 36	1 0.00	4.28	25
b. 01 RURAL HEALTH CLINIC II	1, 363	1, 312				
25 FEDERALLY QUALIFIED HEALTH CENTER	1, 505	1, 312		0.00		
.00 Total (sum of lines 14-26)	Ű	0		0,00		
. 00 Observation Bed Days		34	84			28
. 00 Ambulance Trips	0					29
.00 Employee discount days (see instruction)				0		30
.00 Employee discount days - IRF				0		31
2.00 Labor & delivery days (see instructions)	0	0		0		32
2.01 Total ancillary labor & delivery room				0		32
outpatient days (see instructions)						
3.00 LTCH non-covered days	0					33
3.01  LTCH site neutral days and discharges	0					33

	Financial Systems	DEACONESS (				u of Form CMS-2	2552-10
HOSPI	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-1319	Period: From 10/01/2020 To 09/30/2021	Worksheet S-3 Part I Date/Time Pre 2/28/2022 10:	
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d 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           15.00           20.00           21.00           23.00           24.00           25.00           26.01           27.00           28.00           29.00           30.00           31.00	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 Total Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT BURN INTENSI VE CARE UNIT SURGICAL INTENSI VE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVI DER - IPF SUBPROVI DER - IRF SUBPROVI DER - IRF SUBPROVI DER - IRF SUBPROVI DER - IRF SUBPROVI DER SAILLTY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC II FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instructions)	0.00 0.00 0.00 0.00 0.00 0.00 0.00	0		28     4       49     34       0     0       98     4	265	1.00 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 14.00 15.00 20.00 21.00 22.00 23.00 24.00 24.00 22.00 23.00 24.00 24.00 25.00 26.01 26.00 26.01 26.00 26.01 26.00 26.01 26.00 26.01 26.00 26.01 26.00 26.01 26.00 26.01 26.00 27.00 28.00 24.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 20.00 20.00 20.00 21.00 22.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 21.00 22.00 21.00 22.00 23.00 24.00 25.00 26.00 26.00 27.00 27.00 28.00 20.00 21.00 20.00 21.00 21.00 21.00 21.00 21.00 21.00 22.00 23.00 24.00 26.00 26.00 26.00 27.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 21.00 20.00 21.00 20.00 21.00 22.00 23.00 24.00 20.00 21.00 21.00 22.00 23.00 24.00 26.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20
32. 01 33. 00 33. 01	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0 0		32.01 33.00 33.01

Hear th	Financial Systems	DEACONESS (	GLBSON		In Lie	u of Form CMS-2	2552-10
HOME H	IEALTH AGENCY STATI STI CAL DATA		Provider CO		Period: From 10/01/2020 To 09/30/2021	Worksheet S-4 Date/Time Prep 2/28/2022 10:0	
					Home Health	PPS	JU alli
					Agency I		
					1.	00	
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
		1.00	2.00	3.00	4.00	5. 00	
1 00	HOME HEALTH AGENCY STATISTICAL DATA					0	1 00
1.00 2.00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00	0 198.00		0 0.00	0 0. 00	1.00 2.00
				Number of Emp	oloyees (Full Ti	me Equivalent)	
		Enter the number	r of hours in	Staff	Contract	Total	
		your normal	work week				
		0		1.00	2.00	3.00	
0.00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						0.05
3.00 4.00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		0.00	0. C 0. C		0.00 0.00	3.00 4.00
5.00	Other Administrative Personnel			0.0		0.00	5.00
6.00	Direct Nursing Service			7.3		7.31	6.00
7.00 8.00	Nursing Supervisor Physical Therapy Service			0. C 0. 5		0.00 0.57	7.00 8.00
9.00	Physical Therapy Supervisor			0.0		0.00	9.00
10.00	Occupational Therapy Service			0.3	0.00	0.36	10.00
11.00	Occupational Therapy Supervisor			0.0		0.00	11.00
12.00 13.00	Speech Pathology Service Speech Pathology Supervisor			0. 0 0. 0		0. 05 0. 00	12.00 13.00
14.00	Medical Social Service			0.0		0.00	
15.00	Medical Social Service Supervisor			0.0		0.00	15.00
16.00 17.00	Home Health Aide Home Health Aide Supervisor			0. 9 0. 0		0. 97 0. 00	16.00 17.00
	Other (specify)			0.0		0.00	
						CBSA Data 1.00	
	HOME HEALTH AGENCY CBSA CODES					1.00	
19.00 20.00	Enter in column 1 the number of CBSAs where List those CBSA code(s) in column 1 serviced first code).					1 99915	19.00 20.00
		Full Epi					
		Without W Outliers	ith Outliers	LUPA Epi sode	s PEP Only Epi sodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
01 00	PPS ACTIVITY DATA	1 001	400			1.(00)	01.00
21.00 22.00	Skilled Nursing Visits Skilled Nursing Visit Charges	1, 201 187, 529	430 66, 972		3 9 1 1, 399	1, 683 262, 611	21.00 22.00
23.00	Physical Therapy Visits	944	517	0, , ,	7 8	1, 476	23.00
24.00	Physical Therapy Visit Charges	171, 912	92, 444		1, 348	266, 993	24.00
25.00 26.00	Occupational Therapy Visits Occupational Therapy Visit Charges	466 82, 878	458 82, 228		3 7 30 1, 223	934 166, 909	25.00 26.00
27.00	Speech Pathol ogy Vi si ts	80	77		1 1	159	27.00
28.00	Speech Pathology Visit Charges	15, 111	14, 234	18		29, 711	28.00
29.00 30.00	Medical Social Service Visits Medical Social Service Visit Charges	2 494	0		0 0 0 0	2 494	29.00 30.00
30.00	Home Health Aide Visits	85	104		0 0	494 189	30.00
	Home Health Aide Visit Charges	6, 063	7, 550		0 0	13, 613	32.00
32.00	Total visits (sum of lines 21, 23, 25, 27,	2, 778	1, 586	5	64 25	4, 443	33.00
32. 00 33. 00							
33.00	29, and 31)	о	0		0 0	0	34.00
	29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 463, 987	0 263, 428			0 740, 331	34.00 35.00
<ul><li>33. 00</li><li>34. 00</li></ul>	29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) Total Number of Episodes (standard/non	-	-	8, 76			35.00
33.00 34.00 35.00	29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	463, 987	-	8, 76	4, 153	740, 331	35. 00 36. 00

Heal th	Financial Systems	DEACONES	S GI BSON		In Lie	eu of Form CMS-2	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Period:	Worksheet S-8	
			Component		From 10/01/2020 To 09/30/2021		
					RHC I	Cost	
					1	. 00	1
1 00	Clinic Address and Identification				7054 0 00055		1 00
1.00	Street		Ci	ty	7851 S. PROFES State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		FORT BRANCH		11	47648	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for			0	3.00
					t Award .00	Date 2.00	
	Source of Federal Funds			<u> </u> I	. 00	2.00	-
4.00	Community Health Center (Section 330(d), PHS						4.00
5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6.00 7.00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	U(U), PHS ACT)					6.00 7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h yes or "N" for no in column 1. If yes, indic. 2. (Enter in subscripts of line 11 the type o	ate number of	other operatio	ns in column	N	0	10.00
	hours.)	•					
		Sur from	nday to	from Mo	nday to	Tuesday from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08: 00	17:00	08: 00	11.00
					1.00	2.00	
	Have you received an approval for an exception				N		12.00
13.00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col- number of providers included in this report.	umn 1. If yes,	enter in colu	mn 2 the	N	0	13.00
	numbers below.				1	0.01	
					der name .00	CCN number 2.00	
14.00	RHC/FQHC name, CCN number					2100	14.00
		Y/N	V	XVIII	XIX	Total Visits	
15.00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	5.00	15.00
15.00	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and						15.00
	4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider. (see instructions)						
				inty			
2.00	City, State, ZIP Code, County		4. GI BSON	00			2.00
2.00	orty, state, zir code, county	Tuesday		esday	Thu	rsday	2.00
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
11, 00	Facility hours of operations (1) CLINIC	17: 00	08: 00	17:00	08: 00	17:00	11.00
	1		1- 5. 00	1	1- 5. 55	1	

Health Financial Systems	DEACONESS	GI BSON		In Lieu	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1319	Period: From 10/01/2020	Worksheet S-8	;
		Component	CCN: 15-8524	To 09/30/2021	Date/Time Pre 2/28/2022 10:	
				RHC I	Cost	
	Fri	Fri day Sa		turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17:00				11.00

Heal th	Financial Systems	DEACONES	S GI BSON		In Lie	eu of Form CMS-2	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	
			Component		From 10/01/2020 To 09/30/2021		
					RHC II	Cost	
					1	. 00	
1 00	Clinic Address and Identification Street						1 00
1.00	Street		Ci	ty	510 N MALN ST. State	ZIP Code	1.00
			1.	00	2.00	3.00	
2.00	City, State, ZIP Code, County		PRINCETON		11	47670	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rur	al or "U" for			0	3.00
					t Award .00	Date 2.00	
	Source of Federal Funds			<u> </u> I	. 00	2.00	
4.00	Community Health Center (Section 330(d), PHS						4.00
5.00	Migrant Health Center (Section 329(d), PHS Ad						5.00
6.00 7.00	Health Services for the Homeless (Section 34) Appalachian Regional Commission	U(d), PHS ACT)					6.00 7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a he yes or "N" for no in column 1. If yes, indica				N	0	10.00
	2. (Enter in subscripts of line 11 the type o hours.)	f other operat	tion(s) and the	operati ng			
			nday		nday	Tuesday	
			to 2.00	from 3.00	4.00	from 5.00	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	3.00	
11.00	CLINIC			08: 00	17:00	08: 00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception	on to the proc	uctivity stand	ard?	N	2.00	12.00
13.00	Is this a consolidated cost report as defined				Ν	0	13.00
	30.8? Enter "Y" for yes or "N" for no in colu number of providers included in this report.						
	numbers below.			-			
					der name	CCN number	
14 00	RHC/FQHC name, CCN number			1	. 00	2.00	14.00
11.00		Y/N	V	XVIII	XI X	Total Visits	11.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in						15.00
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)			L			
				nty 00	-		
2.00	City, State, ZIP Code, County		GI BSON				2.00
		Tuesday	Wedne	esday		rsday	
		<u>to</u> 6. 00	from 7.00	to 8.00	from 9.00	to 10.00	
	Facility hours of operations (1)	0.00	7.00	0.00	7.00	10.00	
11.00		17: 00	08: 00	17: 00	08: 00	17:00	11.00

5					u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1319	Period:	Worksheet S-8	
		Component	CCN: 15-8553	From 10/01/2020 To 09/30/2021	Date/Time Pre 2/28/2022 10:	
				RHC II	Cost	
	Fri	Fri day S		turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC	08: 00	17:00				11.00

Heal th	Financial Systems DEAC	ONESS GIBSON		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CO	CN: 15-1319	Peri od:	Worksheet S-1	0
				From 10/01/2020 To 09/30/2021	Date/Time Pre 2/28/2022 10:	
					1.00	
1.00	Uncompensated and indigent care cost computation Cost to charge ratio (Worksheet C, Part I line 202 col	ump 2 divided by Li	ino 202 colum	2 0)	0. 450945	1.00
	Medicaid (see instructions for each line)			10)	0. 450945	1.00
2.00	Net revenue from Medicaid				2, 861, 466	2.00
3.00	Did you receive DSH or supplemental payments from Medi	cai d?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or s		ts from Medic	ai d?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental pa	ayments from Medicai	id		0	5.00
6.00	Medi cai d charges		12, 722, 532			
7.00	Medicaid cost (line 1 times line 6)		5, 737, 162	•		
8.00	Difference between net revenue and costs for Medicaid < zero then enter zero)	nes 2 and 5; if	2, 875, 696	8.00		
0.00	Children's Health Insurance Program (CHIP) (see instru	actions for each lir	ne)		0	
9. 00 10. 00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				0	
	Stand-alone CHIP cost (line 1 times line 10)	0	•			
	Difference between net revenue and costs for stand-al	one CHIP (line 11 mi	inus line 9:	if < zero then	0	
12100	enter zero)			2010 thom	0	12:00
	Other state or local government indigent care program					
	Net revenue from state or local indigent care program					13.00
14.00	Charges for patients covered under state or local indi	gent care program	(Not included	in lines 6 or	0	14.00
15.00	10) State or local indigent care program cost (line 1 time	ac line 14)			0	15.00
	Difference between net revenue and costs for state or		e program (Li	ne 15 minus line		
101.00	13; if < zero then enter zero)	food find gone out	o program (ri		, u	
	Grants, donations and total unreimbursed cost for Medi instructions for each line)	caid, CHIP and stat	te/local indi	gent care progra	ms (see	
17.00	Private grants, donations, or endowment income restric	cted to funding char	rity care		0	17.00
	Government grants, appropriations or transfers for sup				0	
19.00	Total unreimbursed cost for Medicaid , CHIP and state 8, 12 and 16)	and local indigent	care program	s (sum of lines	2, 875, 696	19.00
			Uni nsured	Insured	Total (col. 1	
			patients 1.00	2.00	+ col. 2) 3.00	
	Uncompensated Care (see instructions for each line)		1.00	2.00	5.00	
20.00	Charity care charges and uninsured discounts for the e	entire facility	317, 84	8 0	317, 848	20.00
	(see instructions)					
21.00	Cost of patients approved for charity care and uninsur instructions)	red discounts (see	143, 33	2 0	143, 332	21.00
22.00	Payments received from patients for amounts previously charity care	y written off as		0 0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		143, 33	2 0	143, 332	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges f		yond a length	of stay limit	N	24.00
25.00	imposed on patients covered by Medicaid or other indig If line 24 is yes, enter the charges for patient days		t care progra	m's length of	0	25.00
	stay limit				1 005 /05	
	Total bad debt expense for the entire hospital complex				1, 285, 625	•
	Medicare reimbursable bad debts for the entire hospita Medicare allowable bad debts for the entire hospital of				161, 303 248, 158	•
	Non-Medicare bad debt expense (see instructions)	Sompler (See Institut	51101137		1, 037, 467	•
	Cost of non-Medicare and non-reimbursable Medicare bac	d debt expense (see	instructions	)	554, 696	
30.00	Cost of uncompensated care (line 23 column 3 plus line				698, 028	•
31.00	Total unreimbursed and uncompensated care cost (line 1				3, 573, 724	31.00

	Financial Systems	DEACONESS (		CN 15 1010		u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	UN: 15-1319	Period: From 10/01/2020	Worksheet A	
					To 09/30/2021	Date/Time Pre 2/28/2022 10:	
	Cost Center Description	Sal ari es	Other	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col. 2)	ions (See	Trial Balance	
					A-6)	(col. 3 +-	
		1.00	2.00	2.00	4.00	col. 4)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		2 047 420	2 047 43	0 464 612	2, 524, 143	1.00
4.00		96, 983	2,067,630				
	00400 EMPLOYEE BENEFITS DEPARTMENT		2, 304, 969 4, 457, 409				
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 446, 488					
7.00	00700 OPERATION OF PLANT	208, 130	1, 127, 401	1, 335, 53			
8.00	00800 LAUNDRY & LINEN SERVICE	66, 313	28, 469				
9.00	00900 HOUSEKEEPI NG	284, 260	79, 638				
10.00	01000 DI ETARY	328, 368	244, 625				
11.00		0	0		0 417, 302		
13.00	01300 NURSI NG ADMI NI STRATI ON	94, 813	10, 848				
14.00	01400 CENTRAL SERVICE & SUPPLY	140, 697	69, 739				
15.00	01500 PHARMACY	224, 218	3, 147, 002				
16.00	01600 MEDI CAL RECORDS & LI BRARY	106, 442	39, 061	145, 50	03 0	145, 503	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2,081,655	876, 873				
31.00	03100 I NTENSI VE CARE UNI T	0	0		0 22, 673	22, 673	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 181, 704	1, 145, 439				1
54.00	05400 RADI OLOGY-DI AGNOSTI C	972, 095	602, 158				
54.03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	142, 349				
60.00	06000 LABORATORY	761, 938	2, 320, 023				
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	41, 088			41, 088	
65.00	06500 RESPI RATORY THERAPY	504, 620	509, 022				
66.00	06600 PHYSI CAL THERAPY	-40, 146	2, 060, 521	2, 020, 37	5 -17, 470	2, 002, 905	66.00
67.00	06700 OCCUPATI ONAL 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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 413, 196	413, 196	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 123, 981	123, 981	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00	03480 I NFUSI ON THERAPY	121, 200	56, 576	177, 77	-2,003	175, 773	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	328, 428	410, 898	739, 32	-20, 625	718, 701	88.00
88.01	08801 RURAL HEALTH CLINIC II	735, 378	366, 757	1, 102, 13	5 -29, 777	1, 072, 358	88.01
90.00	09000 CLI NI C	59, 443	26, 603	86, 04	6 0	86, 046	90.00
90.01	09001 DI ABETES	0	1, 450	1, 45	0 0	1, 450	90.01
90.02	09002 OP PSYCH	0	0		0 0	0	90.02
90.03	09003 PALN MANAGEMENT	125, 685	185, 396	311, 08	-21, 652	289, 429	90.03
91.00	09100 EMERGENCY	1, 148, 513	1, 579, 747	2, 728, 26	-13, 305	2, 714, 955	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS					•	
101.00	10100 HOME HEALTH AGENCY	453, 033	350, 445	803, 47	8 -782	802, 696	101.00
	SPECIAL PURPOSE COST CENTERS	· · · · ·					
113.00	11300 INTEREST EXPENSE		456, 513	456, 51	3 -456, 513	0	1113.00
118.00		11, 430, 258	24, 708, 649				
2. 5.	NONREI MBURSABLE COST CENTERS	,,	.,,,				1
194.00	07950 MOB	1, 363, 303	1, 294, 412	2, 657, 71	5 -260, 695	2, 397, 020	194.00
	07951 FOUNDATI ON	-4, 215	346				194.01
	07952 ASC	0	0		0 0		194.02
	07953 SNF - PERRY CO.	0	0		0 0		194.02
	07954 TELE BEHAVI ORAL	0	0		0 0		194.04
200.00		12, 789, 346	26,003,407				
_00.00		12, 107, 540	20,000,407	1 00,772,70	0	1 00, 172, 100	

CLASS	Financial Systems IFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	DEACONESS DE EXPENSES	Provider CC	N: 15-1319	Peri od:	u of Form CN Worksheet A	
					From 10/01/2020 To 09/30/2021	Date/Time F	
						2/28/2022	
	Cost Center Description	Adjustments	Net Expenses				
		(See A-8)	For				
			Allocation				
		6.00	7.00				
	SENERAL SERVICE COST CENTERS	1					
00 0	DO100 CAP REL COSTS-BLDG & FIXT	-74, 317	2, 449, 826				1.
00 0	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 442, 931	3, 894, 422				4.
00 0	DO500 ADMINI STRATI VE & GENERAL	750, 411	6, 780, 489				5.
00 0	00700 OPERATION OF PLANT	485, 973	2, 159, 484				7
00 0	00800 LAUNDRY & LINEN SERVICE	0	94, 104				8
	00900 HOUSEKEEPI NG	191, 054	514, 186				9
	D1000 DI ETARY	67, 189	215, 059				10
	D1100 CAFETERI A	-116, 536					11
	01300 NURSI NG ADMI NI STRATI ON	90, 736					13
		90,730					14
	01400 CENTRAL SERVICE & SUPPLY	-	209, 023				
	01500 PHARMACY	292, 963	3, 650, 717				15
	01600 MEDI CAL RECORDS & LI BRARY	76, 667	222, 170				16
	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	-374, 816					30
. 00 0	03100 I NTENSI VE CARE UNI T	0	22, 673				31
A	NCILLARY SERVICE COST CENTERS						
. 00 0	D5000 OPERATING ROOM	-657, 899	1, 341, 179				50
. 00 0	05400 RADI OLOGY-DI AGNOSTI C	-589	1, 471, 374				54
. 03 0	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	142, 349				54
	06000 LABORATORY	0	3,054,052				60
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	41, 088				62
	06500 RESPIRATORY THERAPY	-359,675	645, 755				65
	06600 PHYSI CAL THERAPY	-337, 075	2,002,905				66
		-					
	06700 OCCUPATI ONAL THERAPY	0	0				67
	06800 SPEECH PATHOLOGY	0	0				68
	06900 ELECTROCARDI OLOGY	0	0				69
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	413, 196				71
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	123, 981				72
. 00 0	07300 DRUGS CHARGED TO PATIENTS	0	0				73
. 00 0	03480 I NFUSI ON THERAPY	0	175, 773				76
0	DUTPATIENT SERVICE COST CENTERS						
. 00 0	08800 RURAL HEALTH CLINIC	-36, 425	682, 276				88
	08801 RURAL HEALTH CLINIC II	-60, 713	1,011,645				88
	09000 CLINIC	0	86, 046				90
	09001 DI ABETES	0	1, 450				90
	09002 OP PSYCH		0				90
	09003 PALN MANAGEMENT	0					90
		0	289, 429				
	09100 EMERGENCY	0	2, 714, 955				91
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92
0	THER REIMBURSABLE COST CENTERS	1	L 1				
1.001	10100 HOME HEALTH AGENCY	0	802, 696				101
S	PECIAL PURPOSE COST CENTERS	1					
	1300 INTEREST EXPENSE	0	0				113
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 716, 954	38, 116, 556				118
N	IONREI MBURSABLE COST CENTERS						
	07950 MOB	-57, 183	2, 339, 837				194
	07951 FOUNDATI ON	0.,100	-3, 869				194
	07952 ASC		-3, 807				194
		0					194
	07953 SNF – PERRY CO. 07954 TELE BEHAVI ORAL	0	0				194

SSI FI CATI ONS			Provider CCN: 15-1	1319   Period:   From 10/01/2020	Worksheet A-6
				To 09/30/2021 I	Date/Time Prepar 2/28/2022 10:06
	Increases				272872022 10.00
Cost Center	Line #	Salary	Other		
2.00 A - CAFETERIA	3.00	4.00	5.00		
CAFETERIA	11.00	239, 145	178, 157		1
0		239, 145	178, 157		
B - MED SUPPLY CHG PTS MEDICAL SUPPLIES CHARGED TO	71.00	0	412 104		1
PATIENT	71.00	0	413, 196		1
IMPL. DEV. CHARGED TO	72.00	о	123, 981		2
PATIENTS					
	0.00 0.00	0	0		3
	0.00	0	0		5
	0.00	О	0		6
	0.00	0	0		
	0.00 0.00	0	0		8
	0.00	0	0		10
	0.00	0	0		1
	0.00	0	0		12
	0.00	0	0		1:
	0.00 0.00	0	0		14
	0.00	0	0		1
	0.00	0	0		1
	0.00	0	0		11
	0.00 0.00	0	0		10
	0.00	0	0		2
0		- — — <sub>0</sub>	537, 177		-
C - BUSINESS HEALTH SER					
EMPLOYEE BENEFITS DEPARTMENT	4.00	14, 646	$ \frac{7, 192}{7, 102}$		
D – INTEREST		14, 646	7, 192		
CAP REL COSTS-BLDG & FIXT	1.00	0	456, 513		
0		0	456, 513		
E – QUALI TY SERVI CES ADMI NI STRATI VE & GENERAL	5.00	83, 722	58, 819		
		83, 722	<u>58, 819</u> 58, 819		
F - HEALTH INSURANCE		· · · · · ·			
EMPLOYEE BENEFITS DEPARTMENT	4.00	0	27, 705		
	0.00 0.00	0	0		
	0.00	0	0		
	0.00	О	0		
	0.00	0	0		
	0.00	0	0		
	0. 00 0. 00	0	0		
	0.00	0	0		1
	0.00	0	0		1
	0.00	0	0		1
	0.00	0	0		1
	0. 00 0. 00	0	0		1
0		0	27, 705		
G - MALPRACTICE RECLASS					
ADMI NI STRATI VE & GENERAL	5.00	0	32, 811		
	0. 00 0. 00	0	0		
	0.00	0	ő		
	0.00	0	0		
		0	32, 811		
H - MOB COLLECTION EXPENSE ADMINISTRATIVE & GENERAL	5.00	0	803		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
		0	803		
I - UTILITIES RECLASS OPERATION OF PLANT	7.00	0	139, 334		
NURSING ADMINISTRATION	13.00	0	139, 334		
	0.00	0	0		
	0.00	0	0		4
	0.00	0	0		5
	0.00	0	0		

Heal th	Financial Systems		DEACONESS (	GI BSON		In Lieu	」of Form CMS	-2552-10
RECLASS	SI FI CATI ONS			Provider CCN	I: 15-1319	Peri od:	Worksheet A-	6
						From 10/01/2020 To 09/30/2021	Date/Time Pr 2/28/2022 10	
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2. 00	3.00	4.00	5.00				
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
9.00	L	0.00	0	0				9.00
	0		0	139, 477				
	J - MAINTENANCE RECLASS							
1.00	OPERATION OF PLANT	7.00	0	199, 489				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
9.00		0.00	0	0				9.00
10.00		0.00	0	0				10.00
11.00		0.00	0	0				11.00
12.00		0.00	0	0				12.00
13.00		0.00	0	0				13.00
	0 — — — — — — — —			199, 489				
	K – PTO ACCRUAL RECLASS							
1.00	PHYSI CAL THERAPY	66.00	63, 991	0				1.00
2.00	FOUNDATI ON	194.01	4, 396	0				2.00
	TOTALS		68, 387	ō				
	L - ICU RECLASS							1
1.00	INTENSIVE CARE UNIT	31.00	16, 161	6, 512				1.00
	TOTALS		16, 161	6, 512				1
500.00	Grand Total: Increases		422, 061	1, 644, 655				500.00

Heal th Financial	Systems
RECLASSI FI CATI ON	IS

	Financial Systems		DEACONESS				u of Form CMS-2552-10
RECLAS	SI FI CATI ONS			Provi der	CCN: 15-1319	Period: From 10/01/2020	Worksheet A-6
						To 09/30/2021	
		Decreases				-	2/20/2022 10.00 um
	Cost Center 6.00	Li ne # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Re 10.00	<u>f.</u>	
	A - CAFETERIA	7.00	0.00	7.00	10.00		
1.00	DI ETARY	10.00	239, 145	<u>178, 1</u> 57		0	1.00
			239, 145	178, 157	7		
1.00	B - MED SUPPLY CHG PTS EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4	1	0	1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	20, 118		0	2.00
3.00	OPERATION OF PLANT	7.00	0	843		0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	651		0	4.00
5.00 6.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	0	34, 010		0	5.00 6.00
7.00	CENTRAL SERVICE & SUPPLY	14.00	0	2, 682 130		0	7.00
8.00	PHARMACY	15.00	0	19		0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	7,443	3	0	9.00
10.00	OPERATING ROOM	50.00	0	216, 078		0	10.00
11.00 12.00	RADI OLOGY-DI AGNOSTI C LABORATORY	54.00 60.00	0	10, 535 9, 176		0	11.00
13.00	RESPI RATORY THERAPY	65.00	0	328		0	13.00
14.00	PHYSI CAL THERAPY	66.00	0	99		0	14.00
15.00	INFUSION THERAPY	76.00	0	2,003		0	15.00
16.00	RURAL HEALTH CLINIC	88.00	0	1, 496		0	16.00
17.00 18.00	RURAL HEALTH CLINIC II PAIN MANAGEMENT	88. 01 90. 03	0	611 21, 652		0	17.00 18.00
19.00	EMERGENCY	90.03	0	7,620		0	19.00
20.00	HOME HEALTH AGENCY	101.00	0	600		0	20.00
21.00	МОВ	1 <u>94.</u> 00	0	20 <u>1,0</u> 79		Q	21.00
			0	537, 177	7		
1.00	C - BUSINESS HEALTH SER MOB	194.00	14, 646	7, 192		0	1.00
1.00			14, 646	<u>7, 192</u>			1.00
	D - INTEREST			•			
1.00	INTEREST EXPENSE	1 <u>13.</u> 00	0	45 <u>6, 5</u> 13		10	1.00
	0 E - QUALITY SERVICES		0	456, 513	3		
1.00	ADULTS & PEDIATRICS	30.00	83, 722	58, 819	9	0	1.00
	0		83, 722	58, 819		-	
	F - HEALTH INSURANCE				1		
1.00	ADMI NI STRATI VE & GENERAL	5.00		2,038		0	1.00
2.00 3.00	HOUSEKEEPI NG DI ETARY	9.00 10.00		642 1, 043		0	2.00 3.00
4.00	CENTRAL SERVICE & SUPPLY	14.00		688		0	4.00
5.00	PHARMACY	15.00		597		0	5.00
6.00	ADULTS & PEDIATRICS	30.00		1, 805		0	6.00
7.00 8.00	OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50.00 54.00		1, 328 182		0	7.00 8.00
9.00	LABORATORY	60.00		460		0	9.00
10.00	PHYSI CAL THERAPY	66.00		1, 143		0	10.00
11.00	RURAL HEALTH CLINIC	88.00		2, 588	3	0	11.00
12.00	RURAL HEALTH CLINIC II	88. 01		3, 042		0	12.00
13.00	EMERGENCY	91.00		460		0	13.00
14.00 15.00	HOME HEALTH AGENCY MOB	101.00 194.00		182 11, 507		0	14.00 15.00
15.00				27, 705		5	13.00
	G - MALPRACTICE RECLASS						
1.00	OPERATING ROOM	50.00	0	5,089		0	1.00
2.00	RESPI RATORY THERAPY	65.00	0	205		0	2.00
3.00 4.00	RURAL HEALTH CLINIC RURAL HEALTH CLINIC II	88. 00 88. 01	0	5, 281 12, 758		0	3.00 4.00
5.00	MOB	194.00	0	9, 478		0	5.00
	TOTALS			32, 811		-	
	H - MOB COLLECTION EXPENSE				1		
1.00	OPERATING ROOM	50.00	0	229		0	1.00
2.00 3.00	RURAL HEALTH CLINIC RURAL HEALTH CLINIC II	88. 00 88. 01	0	150 308		0	2.00 3.00
3.00 4.00	MOB	194.00	0	116		0	4.00
	0 — — — — —		<u>0</u>	803		1	
	I - UTILITIES RECLASS				-1	-	
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	23, 646		0	1.00
2.00 3.00	HOUSEKEEPI NG ADULTS & PEDI ATRI CS	9.00 30.00	0	6, 114 720		0	2.00 3.00
3.00 4.00	OPERATING ROOM	30.00 50.00	0	63, 795		0	4.00
5.00	PHYSI CAL THERAPY	66.00	0	12, 551		0	5.00
6.00	RURAL HEALTH CLINIC	88.00	0	11, 110	D	0	6.00
7.00	RURAL HEALTH CLINIC II	88.01	0	13, 058		0	7.00
8.00	EMERGENCY	91.00	0	56		0	8.00

leal th	Financial Systems		DEACONESS	GLBSON		In Lieu of Form (		
RECLAS	SI FI CATI ONS			Provider (	CCN: 15-1319	Period:	Worksheet	A-6
						From 10/01/2020 To 09/30/2021	Date/Time 2/28/2022	Prepared: 10:06 am
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	°.		
	6.00	7.00	8.00	9.00	10.00			
9.00	MOB	194.00	0	8, 427		Q		9.0
	0		0	139, 477				
	J - MAINTENANCE RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4, 172		0		1.0
2.00	LAUNDRY & LINEN SERVICE	8.00	0	27		0		2.0
3.00	DI ETARY	10.00	0	4, 096		0		3.0
4.00	CENTRAL SERVICE & SUPPLY	14.00	0	595		0		4.0
5.00	PHARMACY	15.00	0	12, 850		0		5.0
5.00	ADULTS & PEDIATRICS	30.00	0	1, 582		0		6.0
7.00	OPERATING ROOM	50.00	0	41, 546		0		7.0
3.00	RADI OLOGY-DI AGNOSTI C	54.00	0	91, 573		0		8.0
9.00	LABORATORY	60.00	0	18, 273		0		9.0
10.00	RESPI RATORY THERAPY	65.00	0	7,679		0		10.0
11.00	PHYSI CAL THERAPY	66.00	0	3, 677		0		11.0
12.00	EMERGENCY	91.00	0	5, 169		0		12.0
13.00	MOB	194.00	0	8, 250		0		13.0
	0		0	199, 489				
	K - PTO ACCRUAL RECLASS							
1.00	PHYSI CAL THERAPY	66.00	0	63, 991		0		1.0
2.00	FOUNDATI ON	194.01	0	4, 396		0		2.0
	ITOTALS	+	o	68, 387		7		1

	L - ICU RECLASS	 			
1.00	ADULTS & PEDIATRICS	 1 <u>6, 1</u> 61	6, 512	0	1.00
	TOTALS	16, 161	6, 512		
500.00	Grand Total: Decreases	353, 674	1, 713, 042		500.00

Health Financial Systems	DEACONESS	GI BSON		Ir	n Lieu of Form CMS	-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1319	Period: From 10/01/ To 09/30/		repared:
			Acquisition	IS		
	Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals an Retirements	
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00 Land	680, 034			0	0 258, 79	0 1.00
2.00 Land Improvements	0	7, 337, 196		0 7,337	7, 196	0 2.00
3.00 Buildings and Fixtures	20, 496, 106	0		0	0 20, 494, 40	6 3.00
4.00 Building Improvements	0	0		0	0	0 4.00
5.00 Fixed Equipment	22, 230, 061	0		0	0 13, 860, 12	8 5.00
6.00 Movable Equipment	0	0		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)	43, 406, 201	7, 337, 196		0 7,337	7, 196 34, 613, 32	4 8.00
9.00 Reconciling Items	0	0		0	0	0 9.00
10.00 Total (line 8 minus line 9)	43, 406, 201	7, 337, 196		0 7,337	7, 196 34, 613, 32	4 10.00
	Endi ng	Ful I y				
	Bal ance	Depreci ated				
		Assets				
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00 Land	421, 244	0				1.00
2.00 Land Improvements	7, 337, 196	0				2.00
3.00 Buildings and Fixtures	1, 700	0				3.00
4.00 Building Improvements	0	0				4.00
5.00 Fixed Equipment	8, 369, 933	0				5.00
6.00 Movable Equipment	0	0				6.00
7.00 HIT designated Assets	0	0				7.00
8.00 Subtotal (sum of lines 1-7)	16, 130, 073	0				8.00
9.00 Reconciling Items	0	0				9.00
10.00 Total (line 8 minus line 9)	16, 130, 073	0				10.00

Health Financial Systems	DEACONESS	GI BSON		In Lie	u of Form CMS-:	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1319	Period: From 10/01/2020	Worksheet A-7	
				To 09/30/2021	Date/Time Pre	
					2/28/2022 10:	<u>06 am</u>
		SU	JMMARY OF CAP	I TAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
				(see	instructions)	
				instructions)		
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	NN 2, LINES 1 a	and 2			
1.00 CAP REL COSTS-BLDG & FIXT	1, 884, 007	0		0 166, 372	17, 251	1.00
3.00 Total (sum of lines 1-2)	1, 884, 007	0		0 166, 372	17, 251	3.00
	SUMMARY O	F CAPI TAL				
Cost Center Description	0ther	Total (1)				
	Capi tal -Rel at					
	ed Costs (see					
	instructions)					
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1.00 CAP REL COSTS-BLDG & FLXT	0	2,067,630	1			1.00
3.00 Total (sum of lines 1-2)	0	2,067,630				3.00

Health Financial Systems	DEACONESS	GIBSON		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 10/01/2020 Fo 09/30/2021	Worksheet A-7 Part III Date/Time Pre 2/28/2022 10:0	pared:
	COMF	PUTATION OF RA	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 -	Ratio (see instructions)	Insurance	
	1.00	2.00	<u>col.2)</u> 3.00	4,00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 CAP REL COSTS-BLDG & FIXT	16, 130, 073	0	16, 130, 073	3 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	16, 130, 073	0	16, 130, 073	1. 000000	0	3.00
	ALLOCA	FION OF OTHER (	CAPI TAL	SUMMARY C	F CAPI TAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capital -Relat				
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		0		1 004 007	202 10/	1 00
1.00 CAP REL COSTS-BLDG & FIXT	0			1, 884, 007 1 884 007		1.00
3.00 Total (sum of lines 1-2)	0	0	IMMARY OF CAPI	1/001/001	382, 196	3.00
		50	JWWARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see	9 through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	-	4//	47.55		0.440.551	
1.00 CAP REL COSTS-BLDG & FIXT	0				_// ===	1.00
3.00  Total (sum of lines 1-2)	0	166, 372	17, 25	0	2, 449, 826	3.00

Health Financial Systems

Health Financial Systems		DEACONESS			u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				eriod: rom 10/01/2020 o 09/30/2021	Worksheet A-8 Date/Time Pre 2/28/2022 10:	
			Expense Classification on To/From Which the Amount is			
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	(2)	2.00	3.00	4.00	Ref. 5.00	
1.00 Investment income - CAP REL	В		CAP REL COSTS-BLDG & FIXT	1.00	10	1.00
2.00 COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	*** Cost Center Deleted ***	2.00	0	2.00
COSTS-MVBLE EQUIP (chapter 2)		0	Cost center bereted	2.00	0	
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time		0		0.00	0	4.00
discounts (chapter 8) 5.00 Refunds and rebates of	А	-1 124	ADMI NI STRATI VE & GENERAL	5.00	0	5. OC
expenses (chapter 8)	~					
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Tel ephone services (pay stations excluded) (chapter 21)	А	-5, 924	OPERATION OF PLANT	7.00	0	7.00
3.00 Television and radio service	А	-132	OPERATION OF PLANT	7.00	0	8.00
(chapter 21) 9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provi der-based physi ci an	A-8-2	-1, 354, 881		0.00	0	10.00
adjustment 11.00 Sale of scrap, waste, etc.		0		0.00	0	11.00
(chapter 23)				0.00		
12.00 Related organization transactions (chapter 10)	A-8-1	3, 642, 903			0	12.00
13.00 Laundry and linen service		0		0.00		13.00
<ul><li>14.00 Cafeteria-employees and guests</li><li>15.00 Rental of quarters to employee</li></ul>		-116, 536	CAFETERI A	11.00 0.00	0	14.00 15.00
and others		C				
16.00 Sale of medical and surgical supplies to other than		0		0.00	0	16.00
patients 17.00 Sale of drugs to other than		0		0.00	0	17. OC
patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts	В	-3, 556	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health		0		0.00	0	19.00
education (tuition, fees, books, etc.)						
20.00 Vending machines		0		0.00		
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare		0		0.00	0	22.00
overpayments and borrowings to repay Medicare overpayments						
23.00 Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
therapy costs in excess of limitation (chapter 14)						
24.00 Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
therapy costs in excess of limitation (chapter 14)						
25.00 Utilization review -		0	*** Cost Center Deleted ***	114.00		25.00
physicians' compensation (chapter 21)						
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL		0	*** Cost Center Deleted ***	2.00	0	27.00
COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0	Cost conter bereted	0.00		
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
instructions)						

Heal th	Financial Systems		DEACONESS	GIBSON	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1319	Peri od:	Worksheet A-8	
					From 10/01/2020 To 09/30/2021	Date/Time Pre	pared:
						2/28/2022 10:	<u>06 am</u>
				Expense Classification o			
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)				Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of						
00.00	limitation (chapter 14)				0.00		
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
22 00	Depreciation and Interest MISC INCOME	В	0 710	ADMI NI STRATI VE & GENERAL	5.00	0	33.00
	MISC INCOME	B		RESPIRATORY THERAPY	65.00	0	1
	ADVERTI SI NG	Δ		ADMI NI STRATI VE & GENERAL	5.00	0	33.02
	HAF FEE	A		ADMI NI STRATI VE & GENERAL	5.00	0	
	LOBBYING	A		ADMI NI STRATI VE & GENERAL	5.00	0	34.00
	LOBBYING	A		ADMI NI STRATI VE & GENERAL	5.00	0	
35.02	DONATION	A		ADMI NI STRATI VE & GENERAL	5.00	0	35.02
50.00	TOTAL (sum of lines 1 thru 49)		1, 659, 771		0100	0	50.00
	(Transfer to Worksheet A,						
	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	DEACONES	S GIBSON	In Lie	eu of Form CMS-	2552-10
	STS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-1319	Peri od:	Worksheet A-8	3-1
OFFICE COSTS				From 10/01/2020 To 09/30/2021		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
A. COSIS		MENTS REQUIRED AS A RESULT OF	- TRANSACTIONS WITH RELATED	ORGANIZATIONS OF	R CLAIMED HOME	
1.00		EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFLTS	1, 503, 588	60, 657	1.00
2.00			ADMIN & GENERAL	2, 423, 214		2.00
3.00			MAINTENANCE	492,029		3.00
3.01	9.00	HOUSEKEEPI NG	HOUSEKEEPING	191,054		3.01
3. 02	10.00	DI ETARY	DI ETARY	67, 189	о	3.02
4.00	13.00	NURSING ADMINISTRATION	NURSING ADMIN	90, 736	0	4.00
4.01	15.00	PHARMACY	PHARMACY	292, 963	0	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	MEDI CAL RECORDS	80, 223	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE & GENERAL	203, 817	0	4.03
4.04	30.00	ADULTS & PEDIATRICS	A&P	0	29, 728	4.04
4.05	88.00	RURAL HEALTH CLINIC	MAIN STREET	0	36, 425	4.05
4.06		RURAL HEALTH CLINIC II	FAMILY MEDICAL CLINIC	0	60, 713	4.06
4.07	194.00	MOB	FORT BRANCH	0	57, 183	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	1, 255, 254	1, 483, 474	4.08
	sum of lines 1-4).			6, 600, 067	2, 957, 164	5.00
	column 6, line 5 to					
	A-8, column 2,					
line 12.		beerinte as appropriate) are				

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.

nas no	t been posted to worksneet A,	corumns r and/or 2, the amou	nt arrowable si	ioura permarcatea in corumn	4 of this part.	
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME 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

1 CT IIID GT						
6.00	G		0.00	DEACONESS HOSP	100.00	6.00
7.00	G		0.00	HRS	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	HOME OFFICE				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	DEACONESS GI	BSON	In Lieu	ı of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1319	Peri od:	Worksheet A-8-1
OFFICE COSTS			From 10/01/2020	

From	10/01/2020		
То	09/30/2021	Date/Time	Prepared:
		2/28/2022	10.06 am

			2/28/2022 10:	06 am
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME	
	OFFICE COSTS:			
1.00	1, 442, 931	0		1.00
2.00	1, 194, 230			2.00
3.00	492, 029	0		3.00
3.01	191, 054	0		3.01
3.02	67, 189	0		3.02
4.00	90, 736	0		4.00
4.01	292, 963	0		4.01
4.02	80, 223	0		4.02
4.03	203, 817	0		4.03
4.04	-29, 728	0		4.04
4.05	-36, 425	0		4.05
4.06	-60, 713	0		4.06
4.07	-57, 183	0		4.07
4.08	-228, 220	0		4.08
5.00	3, 642, 903			5.00

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

Related Organization(s)		
and/or Home Office		
Type of Business		
51.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4		
6,00		
IB INTERRELATIONSHIP TO RELA	TED 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 ndor titlo VV/

r er mou	sement under title XVIII.		
6.00	HOME OFFICE		6.00
7.00	PFS		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00		1	00.00
(1) Use	e the following symbols to in	dicate 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 organizati 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.

	Financial Syste		DEACONES	S GI BSON			eu of Form CMS-	
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (		Period: From 10/01/2020 To 09/30/2027		epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADMI NI STRATI VE & GENERAL	304		C	-		1.00
2.00	30.00	ADULTS & PEDIATRICS	345, 088	345, 088	C			2.00
3.00	50.00	OPERATING ROOM	657, 899	657, 899	C	C	0 0	3.00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	589	589	C	C	0 0	4.00
5.00	60.00	LABORATORY	40, 000	0	40, 000	C	0 0	5.00
6.00	65.00	RESPI RATORY THERAPY	351,001	351,001	C	C	0	6.00
7.00	91.00	EMERGENCY	1, 197, 073	0	1, 197, 073	C	0	7.00
8.00	0.00		0	0	C	C	0	8.00
9.00	0.00		0	0	C	C	0	9.00
10.00	0.00		0	0	C	C	0	10.00
200.00			2, 591, 954	1, 354, 881	1, 237, 073		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE	Memberships &	Component	of Mal practi ce	
				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		ADMI NI STRATI VE & GENERAL	0	-				
2.00		ADULTS & PEDIATRICS	0	0	-			
3.00		OPERATING ROOM	0	0	C			3.00
4.00		RADI OLOGY-DI AGNOSTI C	0	0	C	C	-	
5.00		LABORATORY	0	0	C	C	, v	5.00
6.00		RESPI RATORY THERAPY	0	0	C	C	-	
7.00		EMERGENCY	0	0	C	C	0	
8.00	0.00		0	0	C	C	0	8.00
9.00	0.00		0	0	C	C	0	
10.00	0.00		0	0	C	C	, v	
200.00			0	0	C	C	0 0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14	1( 00	17.00	10.00	-	
1 00	1.00	2.00 ADMI NI STRATI VE & GENERAL	15.00	16.00	17.00 C	18.00 304		1 00
1.00 2.00		ADMINISTRATIVE & GENERAL ADULTS & PEDIATRICS		0	-			1.00 2.00
		OPERATING ROOM		0	-			2.00
3.00				0	-			3.00
4.00 5.00		RADI OLOGY-DI AGNOSTI C LABORATORY		0		589		4.00 5.00
		RESPIRATORY THERAPY		0	-	-		6.00
6.00 7.00		EMERGENCY		0		351,001	1	
				0	-			7.00
8.00	0.00			-	-			8.00
9.00	0.00		0	0	-			9.00
10.00	0.00			0	-			10.00
200.00	I		1 0	0	C	1, 354, 881		200.00

REASON	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	DEACONESS ( FURNI SHED BY	SIBSON Provider CCN:		In Lie Period: From 10/01/2020 To 09/30/2021 Physical Therapy	Date/Time Pre 2/28/2022 10:	3-3 epared:
						1.00	
	PART I - GENERAL INFORMATION					1.00	
1.00 2.00 3.00 4.00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis Number of unduplicated days in which therapy nor therapist was on provider site (see instr	or or therapist assistant was o	was on provide			52 780 365 0	2.00 3.00
5.00 6.00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera assistant and on which supervisor and/or ther instructions)	visors or thera py assistants (	include only vi	isits made b		0 0	6.00
7.00 8.00	Standard travel expense rate Optional travel expense rate per mile					3.50 0.00	
		Supervi sors		Assi stants	Ai des	Trai nees	
9.00	Total hours worked	1.00	2.00	<u>3.00</u> 11,824.0	4.00 0 7,417.00	5.00	9.00
10.00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0.00 0.00 44.31	88. 62 44. 31	88. 6 44. 3	2 44.31	0.00	
12. 01 13. 00	Number of travel hours (provider site) Number of travel hours (offsite) Number of miles driven (provider site) Number of miles driven (offsite)	0 0 0 0	0 0 0 0		0 0 0 0		12.00 12.01 13.00 13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00 15.00	Supervisors (column 1, line 9 times column 1, Therapists (column 2 line 9 times column 2					0 1, 047, 090	
16.00 17.00	Therapists (column 2, line 9 times column 2, line 10) Assistants (column 3, line 9 times column 3, line10) Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					1, 047, 843 2, 094, 933	16.00
	Aides (column 4, line 9 times column 4, line					328, 647	
20.00	Trainees (column 5, line 9 times column 5, li Total allowance amount (sum of lines 17-19 fo If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than amount from line 20. Otherwise complete line	r respiratory t therapy or col line 2, make n	umns 1-3 for ph	nysical ther	apy, speech pat	hology or	
	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3,	inees (line 17		of columns	1 and 2, line 9	0.00	21.00
22. 00 23. 00	Weighted allowance excluding aides and traine Total salary equivalency (see instructions)	es (line 2 time	s line 21)			0 2, 423, 580	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW. Standard Travel Allowance	ANCE AND TRAVEL	EXPENSE COMPUT	FATION - PRO	OVIDER SITE		-
	Therapists (line 3 times column 2, line 11)					16, 173	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00 27.00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)				3 and 4 for all	16, 173 1, 278	1
28.00	Total standard travel allowance and standard (27)	travel expense	at the provide	r site (sum	of lines 26 and	17, 451	28.00
20.00	Optional Travel Allowance and Optional Travel		2 11 10 )				1 20. 00
29.00 30.00	Therapists (column 2, line 10 times the sum o Assistants (column 3, line 10 times column 3,		∠, iine 12 )			0	1
31.00	Subtotal (line 29 for respiratory therapy or	,	and 30 for all	others)		0	
32.00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	1 and 2, line	13 for respira		y or sum of	0	32.00
	Standard travel allowance and standard travel Optional travel allowance and standard travel			31)		0	
	Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	expense (sum o	flines 31 and	32)	/ICES OUTSIDE PR	0	1
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	1
37.00 38.00	Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)					0	
39.00	Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel		6)			0	
40.00	Therapists (sum of columns 1 and 2, line 12.0		2, line 10)			0	40.00
41.00	Assistants (column 3, line 12.01 times column		-			0	41.00
	Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum			0.11		0	
	Total Travel Allowance and Travel Expense - 0 46, as appropriate.		•				
	Standard travel allowance and standard travel						44.00

REASON	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	DEACONESS FURNI SHED BY	GIBSON Provider C	Fi Ti	eriod: rom 10/01/2020 o 09/30/2021	u of Form CMS-: Worksheet A-8 Parts I-VI Date/Time Pre 2/28/2022 10:	-3 pared:
				Pr	<u>iysi cal Therapy</u>	Cost	
						1.00	
46.00	Optional travel allowance and optional trave						46.00
		Therapists 1.00	Assistants 2.00	Ai des 3.00	Trai nees 4.00	<u> </u>	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
	Overtime hours worked during reporting	0.00	0.00	0.00	0.00	0.00	47.00
	period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
50.00	CALCULATION OF LIMIT Percentage of overtime hours by category	0.00	0.00	0.00	0.00	0.00	50.00
50.00	(divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	88. 62	88.62	44.31	0.00		52.00
53.00	(see instructions) Overtime cost limitation (line 51 times line		00. 02				52.00
55.00	52)	0	0	0	0		55.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) ( Enter in column 5 the sum of columns 1, 3, and 4 for	0	0	0	0	0	56.00
	respiratory therapy and columns 1 through 3 for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION	AND EXCESS COST	ADJUSTMENT				
	Salary equivalency amount (from line 23) Travel allowance and expense - provider site	(from lines 2)	2 2 4 or 25))			2, 423, 580 0	1
	Travel allowance and expense - provider site			6)		0	1
60.00	Overtime allowance (from column 5, line 56)	<b>,</b>				0	
61.00	Equipment cost (see instructions)					0	
	Supplies (see instructions)					0	
63.00 64.00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (fro	m vour records	)			2, 423, 580 1, 969, 720	
	Excess over limitation (line 64 minus line 6 LINE 33 CALCULATION						65.00
100.00	Line 26 = line 24 for respiratory therapy or	sum of lines 2	24 and 25 for a	all others		16, 173	100.00
	Line 27 = line 7 times line 3 for respirator	y therapy or su	um of lines 3 a	and 4 for all c	others		100. 01
	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION						100. 02
101.00	Line 27 = line 7 times line 3 for respirator	y therapy or su	um of lines 3 a	and 4 for all c	others		101.00
	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31	sum of lines 2	29 and 30 for a	all others			101. 01 101. 02
	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or					0	102.00
	Line 32 = line 8 times columns 1 and 2, line 13 for all others	13 for respira	atory therapy (	or sum of colun	nns 1-3, line		102.01
102.02	Line 35 = sum of lines 31 and 32				l	0	102.02

Health Financial Systems	DEACONESS	GIBSON		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 10/01/2020 Fo 09/30/2021		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL <u>RELATED COSTS</u> BLDG & FI XT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI V E & GENERAL	
GENERAL SERVICE COST CENTERS	0	1.00	4.00	4A	5.00	
1.0000100CAPRELCOSTS-BLDG& FIXT4.0000400EMPLOYEEBENEFITSDEPARTMENT5.0000500ADMINISTRATIVE& GENERAL7.0000700OPERATIONOFPLANT	2, 449, 826 3, 894, 422 6, 780, 489 2, 159, 484	133, 261 668, 387	3, 915, 556 470, 07 63, 93	4 7, 383, 824 7 2, 891, 808	645, 703	
8. 00       00800       LAUNDRY & LI NEN SERVI CE         9. 00       00900       HOUSEKEEPI NG         10. 00       01000       DI ETARY         11. 00       01100       CAFETERI A         13. 00       01300       NURSI NG ADMI NI STRATI ON	94, 104 514, 186 215, 059 300, 766 196, 540	43, 495 24, 549 30, 153 81, 520 7, 365	20, 37 87, 32 27, 40 73, 46 29, 12	4 626, 059 9 272, 621 4 455, 750	139, 791 60, 873 101, 763	9.00 10.00 11.00
14.00         01400         CENTRAL SERVICE & SUPPLY           15.00         01500         PHARMACY           16.00         MEDICAL RECORDS & LIBRARY           INPATIENT ROUTINE SERVICE COST CENTERS           30.00         03000 ADULTS & PEDIATRICS	209, 023 3, 650, 717 222, 170 2, 406, 948	0 35, 810 35, 570 244, 534	43, 22: 68, 87 32, 69 608, 79	9 3, 755, 406 9 290, 439	838, 548 64, 851	15.00
31. 00 03100 I NTENSI VE CARE UNI T ANCI LLARY SERVI CE COST CENTERS	2, 408, 948	51, 661	4, 96			
50.00         05000         OPERATI NG         ROOM           54.00         05400         RADI OLOGY-DI AGNOSTI C           54.03         05401         NUCLEAR         MEDI CI NE-DI AGNOSTI C           60.00         06000         LABORATORY           62.00         06200         WHOLE         BLOOD & PACKED         RED BLOOD CELLS	1, 341, 179 1, 471, 374 142, 349 3, 054, 052 41, 088	136, 196 93, 288 11, 207 40, 827 0	363, 01 298, 62 234, 06	4 1, 863, 286 0 153, 556 4 3, 328, 943	416, 048 34, 287 743, 310	54.00 54.03 60.00
62.00 06500 WHOLE BLOOD & PACKED KED BLOOD CELLS 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY	645, 755 2, 002, 905 0	43, 015 98, 465 0 0	155, 01 7, 32	7 843, 787 5 2, 108, 695	188, 407	65.00
71.0007100MEDICAL SUPPLIES CHARGED TO PATIENT72.0007200IMPL. DEV. CHARGED TO PATIENTS73.0007300DRUGS CHARGED TO PATIENTS76.0003480INFUSION THERAPY	413, 196 123, 981 0 175, 773	95, 770 0 28, 472	37, 23	50         508, 966           50         123, 981           50         0           2         241, 477	113, 645 27, 683 0	71.00 72.00 73.00
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC           88.01         08801         RURAL HEALTH CLINIC           90.00         09000         CLINIC           90.01         09001         DLABETES           90.02         09002         OP	682, 276 1, 011, 645 86, 046 1, 450 0	0 38, 425 0 0	100, 89 225, 90 18, 26	5 1, 275, 975 1 104, 307 0 1, 450	284, 909 23, 290	88. 01 90. 00
90. 03     09003     PAI N MANAGEMENT       91. 00     09100     EMERGENCY       92. 00     09200     OBSERVATI ON BEDS (NON-DI STINCT PART       OTHER     REI MBURSABLE     COST CENTERS	289, 429 2, 714, 955	207, 657	38, 610 352, 819	370, 067 3, 275, 431 0	82, 631 731, 361	90.03 91.00 92.00
101.00 10100 HOME HEALTH AGENCY <u>SPECIAL PURPOSE COST CENTERS</u> 113.00 11300 INTEREST EXPENSE	802, 696	13, 476	139, 170	955, 342	213, 315	101.00 113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	38, 116, 556	2, 226, 265	3, 501, 19	-		118.00
194. 00 07950 MOB 194. 01 07951 FOUNDATI ON 194. 02 07952 ASC 194. 03 07953 SNF - PERRY CO. 194. 04 07954 TELE BEHAVI ORAL	2, 339, 837 -3, 869 0 0 0	188, 631 34, 930 0 0 0	414, 30: 5( ( (		6, 948 0 0	194.00 194.01 194.02 194.03 194.04
200.00Cross Foot Adjustments201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	40, 452, 524	0 2, 449, 826	( 3, 915, 55	0 0 5 40, 452, 524	0	200. 00 201. 00 202. 00

Heal th	Financial Systems	DEACONESS	GI BSON		In Lieu	u of Form CMS-:	2552-10
COST	ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 10/01/2020	Worksheet B Part I	
					o 09/30/2021	Date/Time Pre 2/28/2022 10:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT 7. 00	LINEN SERVICE 8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS	7.00	0.00	9.00	10.00	11.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	3, 537, 511					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	94, 567	287, 810				8.00
9.00	00900 HOUSEKEEPI NG	53, 375		819, 225			9.00
10.00	01000 DI ETARY	65, 559		15, 845			10.00
11.00		177, 241		42, 837		777, 591	
13.00	01300 NURSING ADMINISTRATION	16, 013		3, 870		7,957	
14.00	01400 CENTRAL SERVICE & SUPPLY	0	-	10.010	-	11,808	
15.00		77,858		18, 818		18, 818 8, 933	
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	77, 336	0	18, 691	U	8, 933	16.00
30, 00	03000 ADULTS & PEDIATRICS	531, 667	285, 354	128, 497	411, 358	166, 326	30.00
31.00	03100 I NTENSI VE CARE UNI T	112, 320				1, 356	
51.00	ANCI LLARY SERVICE COST CENTERS	112, 320	2,430	27,147	3, 340	1, 550	51.00
50.00	05000 OPERATI NG ROOM	296, 117	0	71, 569	0	99, 178	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	202, 826		49, 021		81, 586	
54.03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	24, 367		5, 889		0	1
60.00	06000 LABORATORY	88, 766		21, 454		63, 948	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	93, 523	0	22, 604	0	42, 352	65.00
66.00	06600 PHYSI CAL THERAPY	214, 082	0	51, 741	0	2, 001	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	C	0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	( C	0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	( C	0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	208, 222		50, 325		0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	-	C		0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0		0	
76.00	03480 I NFUSI ON THERAPY	61, 904	0	14, 962	0	10, 172	76.00
00 00	OUTPATIENT SERVICE COST CENTERS	0	0	0		0	00.00
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	0 83, 544	-	20, 192	-	0	88.00 88.01
90.00	09000 CLINIC	83, 544		20, 192		4, 989	1
90.00 90.01	09001 DI ABETES	0			-	4, 909	1
90.01	09002 OP PSYCH	0				0	1
90.02	09003 PALN MANAGEMENT	91, 376	0	22, 085	, s	10, 548	1
91.00	09100 EMERGENCY	451, 486		109, 120		96, 392	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1017 100		10,7,120		, 0, 0, 2	92.00
	OTHER REIMBURSABLE COST CENTERS	1	1		· ·		
101.00	10100 HOME HEALTH AGENCY	29, 298	0	7, 081	0	38, 022	101.00
	SPECIAL PURPOSE COST CENTERS				· · · · ·		
113.00	11300 INTEREST EXPENSE						113.00
118.00		3, 051, 447	287, 810	701, 748	414, 898	664, 386	118.00
	NONREI MBURSABLE COST CENTERS						
	07950 MOB	410, 120		99, 122		113, 190	1
	07951 FOUNDATI ON	75, 944		18, 355			194.01
	207952 ASC	0	0	0	-		194.02
	3 07953 SNF - PERRY CO.	0	0	0	0		194.03
	107954 TELE BEHAVI ORAL	0	0		0	0	194.04
200.0		_	_	-		-	200.00
201.0		0				0 777, 591	201.00
202.0	)  TOTAL (sum lines 118 through 201)	3, 537, 511	287, 810	819, 225	414, 898	111, 591	1202. UU

Heal th Finan	cial Systems	DEACONESS	GI BSON		In Lie	u of Form CMS-	2552-10
COST ALLOCAT	FLON - GENERAL SERVICE COSTS		Provider C	CN: 15-1319	Period: From 10/01/2020 To 09/30/2021	Worksheet B Part I Date/Time Pre 2/28/2022 10:	epared: 06 am
	Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CE & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
	AL SERVICE COST CENTERS			1			1 1 00
	CAP REL COSTS-BLDG & FIXT						1.00
	EMPLOYEE BENEFITS DEPARTMENT						4.00
	ADMI NI STRATI VE & GENERAL						5.00
	OPERATION OF PLANT						7.00
	LAUNDRY & LINEN SERVICE						8.00
	HOUSEKEEPI NG DI ETARY						9.00 10.00
	CAFETERIA						11.00
	NURSI NG ADMI NI STRATI ON	312, 904					13.00
	CENTRAL SERVICE & SUPPLY	312, 904	320, 376				14.00
	PHARMACY	9, 416	2,012		76		15.00
	MEDICAL RECORDS & LIBRARY	9,410	2,012		460, 256		16.00
	I ENT ROUTI NE SERVI CE COST CENTERS	0	0		400,230		10.00
	ADULTS & PEDIATRICS	90, 168	15,093		0 30, 037	5, 646, 753	30.00
	INTENSIVE CARE UNIT	0	13, 079		0 158	243, 982	
	LARY SERVICE COST CENTERS	0	0		0 100	243, 702	51.00
	OPERATING ROOM	32, 853	45, 248		0 51,904	2, 848, 194	50.00
	RADI OLOGY-DI AGNOSTI C	41, 784	10, 086		0 101, 848	2, 766, 485	
	NUCLEAR MEDICINE-DIAGNOSTIC	0	153		0 3, 686	221, 938	
	LABORATORY	32, 750	101, 557		0 84, 514	4, 465, 242	
	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	27		0 813	51, 102	
	RESPI RATORY THERAPY	21,005	3, 791		0 24, 813	1, 240, 282	
66.00 06600	PHYSI CAL THERAPY	0	2, 912		0 46, 698	2, 896, 973	
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
	MEDICAL SUPPLIES CHARGED TO PATIENT	0	80, 624		0 0	961, 782	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	24, 192		0 0	175, 856	72.00
	DRUGS CHARGED TO PATIENTS	0	0	4, 720, 8	76 62, 395	4, 783, 271	73.00
	INFUSION THERAPY	5, 339	3, 962		0 3, 069	394, 804	76.00
	TIENT SERVICE COST CENTERS	1 1					
	RURAL HEALTH CLINIC	0	401		0 0	958, 440	
	RURAL HEALTH CLINIC II	0	1, 685		0 0	1, 666, 305	
		2, 634	3, 486		0 2,448	141, 154	
	DI ABETES	0	0		0 54	1, 828	
	OP PSYCH	E 424	U 520		0 0	0	
		5, 626	532 16, 097		0 1, 470 0 46, 349	584, 335	
	EMERGENCY	50, 653	16, 097		0 46, 349	4, 776, 889	
	OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS						92.00
	HOME HEALTH AGENCY	20, 676	3, 640		0 0	1, 267, 374	101 00
	AL PURPOSE COST CENTERS	20,070	3, 040		0 0	1,207,374	
	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	312, 904	315, 504	4, 720, 8	76 460, 256	36, 092, 989	
	IMBURSABLE COST CENTERS	012,701	010,001	1,720,0	100,200	00,072,707	110.00
194.0007950		0	4, 872		0 0	4, 227, 156	194 00
194.0107951		0	1, 372		0 0	132, 379	
194.0207952		0	0		0 0		194.02
	SNF - PERRY CO.	0	0		0 0		194.03
	TELE BEHAVIORAL	0	0		0 0		194.04
200.00	Cross Foot Adjustments	1	-				200.00
201.00	Negative Cost Centers	0	0		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	312, 904	320, 376	4, 720, 8	76 460, 256	40, 452, 524	202.00
		· ·		·	•		-

COST ALLOCATION - GENERAL SERVICE COSTS         Provider CON: 15-1313         Period To 201/2020         Period To 201/2020<	Health Financial Systems	DEACONESS G	GI BSON		In Lieu c	of Form CMS-2552-10
To         09/30/2021         Detect Time Pregards // 22/20/2022         Detect Time Pregards // 22/2022         Detect Time Pregards // 22/20/202 <thdetect 20="" 202<="" 22="" pregards="" td="" th<="" time=""><td></td><td></td><td>Provider C</td><td>CN: 15-1319</td><td></td><td></td></thdetect>			Provider C	CN: 15-1319		
Cost Center Description         Intern & Cost A Post StepDom Adjustments         Total Cost A Post StepDom Adjustments         Total Cost A Post Adjustments         Total Cost A Post Adjustments           1.00         OOIDO CAP ReL COSTS-BLIC & ITYT Adjustments         25.00         20.00           1.00         OOIDO CAP ReL COSTS-BLIC & ITYT Adjustments         10.00         Cost A Post Adjustments         10.00           0.0000 DENTORE DEPENTENT 5.00         0.0000 DENTORE DEPENTENT 5.00         5.00         20.000         10.00           0.00000 DENTORE SERVER         0.0000 DENTORE DEPENTENT 5.00         0.00000 DENTORE DEPENTENT 5.00         5.00         0.00000 DENTORE DEPENTENT 5.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         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         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         10.00         10.00         10.00         10.00         10.00         10.00         10.00         <						
Rest dents Stepdom         20.00           100         Ottolo CAP REL_COST CENTERS         20.00           100         Ottolo CAP REL_COST SUDG & FLAT         4.00           100         Ottolo CAP REL_COST SUDG & FLAT         5.00           100         Ottolo CAP REL_COST CENTERS         7.00           100         Ottolo CAP REL_COST CENTERS         7.00           100         Ottolo CAP REL_COST CENTERS         7.00           1100         Ottolo CAP REL_COST CENTERS         7.00           1000         Ottolo CAP REL_COST CENTERS         7.00 <tr< td=""><td></td><td></td><td></td><td></td><td>2,</td><td>/28/2022 10:06 am</td></tr<>					2,	/28/2022 10:06 am
Cost & Post Adjustments         Zost & Post Adjustments         Zost         Zost <thzost< th="">         Zost         Zost<!--</td--><td>Cost Center Description</td><td></td><td>lotal</td><td></td><td></td><td></td></thzost<>	Cost Center Description		lotal			
Stepdom         25.00         26.00           EFNERAL_SERVICE_COST_CENTERS         1.00           0.100 CAP_REL_COSTS_BLICE AF IXT         1.00           0.00         0.000 MINISTRATIVE A GORFAN.         5.00           0.01         0.000 DEFRATION 0F_PLAYT         5.00           0.01         0.000 DEFRATION 0F_PLAYT         7.00           0.000 COROLUMINSTRATIVE A GORFAN.         9.00           0.000 COROLUMARY & LINEN SERVICE         9.00           0.000 COROLUMARY & LINEN SERVICE         9.00           0.000 COROLUTARY         1.00           0.000 COROLUTIRE SERVICE COST CENTERS         0           0.000 COROLUTIS & PERVICE         0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
Adj ustments         Adj ustments           1.00         ENRERAL-SERVICE COST CENTERS         20.00           1.00         EDRERAL-SERVICE COST CENTERS         1.00           1.00         DOSOD ADMI MISTRATIVE & GERERALT         1.00           1.00         DIGOOD OFERATION OF PLANT         1.00           1.00         DIGOD ADMISTRATIVE & GERERALT         10.00           1.00         DIGOD ADMISTRATIVE & GERERALT         10.00           1.00         DIGOD ADMISTRATIVE RECORDS & LIBRARY         11.00           1.00         DIGOD ADMISTRATIVE RECORDS & LIBRARY         10.00           1.00         DIGOD ADMISTRATIVE RECORDS & LIBRARY         10.00           1.00         DIGOD ADMISTRATIVE RECORD COST CENTERS         0           0.00						
CHURAL SERVICE COST CENTERS         1.00           1.00         CONCAP REL COSTS.BLOB & FIXT         4.00           4.00         CAP REL COSTS.BLOB & FIXT         5.00           4.00         CONCAP REL COSTS.BLOB & FIXT         5.00           4.00         CONCAP REL COSTS.BLOB & FIXT         5.00           6.00         CONCAP REL COSTS.BLOB & FIXT         5.00           7.00         CONCAP REL COSTS.BLOB & FIXT         5.00           6.00         CONCAP REL COSTS.BLOB & FIXT         5.00           7.00         CONTAP REL COSTS.CENTERS         11.00           11.00         CONTAP REL COSTS CENTERS         11.00           11.00         CONTAP REL COST CENTERS         11.00           11.00         CONTAP REL COST CENTERS         11.00           11.00         CONTAP REL COST CENTERS         11.00           11.00         CONTAP REL COST CENTERS         11.00           11.00         CONTAP REL COST CENTERS         11.00           11.00         CONTAP REL COST CENTERS         11.00           11.00         CONTAP REL COST CENTERS         11.00           11.00         CONTAP REL COST CENTERS         11.00           11.00         CONTAP REL COST CENTERS         11.00           11.00						
1.00         ©100C CAP FEL COSTS -BLOG & FLXT         1.00           0.00         ©000C ENLOYCE BENETIS DEPARIMENT         5.00           0.00         ©000C DEPARTI 00 OF PLANT         7.00           0.00         ©000C DEPARTI 00 OF PLANT         7.00           0.00         ©000C DEPARTI 00 OF PLANT         8.00           0.00         ©000C DEPARTI 00 OF PLANT         8.00           0.00         ©000C DEPARTI 00 OF PLANT         9.00           0.0000 DI ETART W         9.00           0.0000 DI ETART W         9.00           0.0000 DI ETART W         11.00           1.000 DI CON DI ETART W         11.00           1.000 DI CON DI ETART W         11.00           1.000 DI CON DI ETART W         11.00           1.000 DI CON DI ETART W         11.00           1.000 DI CON DI ETART W         11.00           1.000 DI CON DI ETART W         0           1.000 DI CON DI ETART W         0           0.000 DI CON DEPART NOT NORM         0           0.000 DI CON DEPART NOR NORM         2.848, 194           0.000 DI CON DEPART NORM         2.848, 194           0.000 DI ADULELAR MED TO PATIENTS         0           0.000 DI CONTRATIONT         0         2.646, 55, 242, 00           <		25.00	26.00			
1.00         00400 EMPLOYEE BENEFITS DEPARTMENT         4.00           0.00         00700 (PPERATION OF PLANT         6.00           0.00         00700 (PPERATION OF PLANT         8.00           0.00         00000 (LUNKEYK & LINN SSEN/CE         8.00           0.00         00000 (DITARY         110.00           11.00         01100 (CAFETERIA         110.00           11.00         01100 (CAFETERIA         110.00           0.00         00000 (PINASINE SAURIN STRATION         13.00           13.00         01300 (DITARY         110.00           0.01         00000 (PINASINE SAURINSTRATION         13.00           14.00         01400 (CARTERIA SERVICE & SUPPLY         15.00           15.00         01500 (DITARY SERVICE COST CENTERS         30.00           0.01         03000 (PINASINE CARE UNIT         2.444.194           50.00         05000 (PREATING ROOM         0         2.444.194           50.00         05000 (PREATING ROOM         0         2.444.194           50.00         05000 (PREATING ROOM STIC         0         2.764.485         54.00           50.00         05000 (PREST RATONT HREAPY         0         2.00         66.00           60.00         06000 (PREST RATONT HREAPY         0		1		-		
5. 00         00500 ADM IN STRATI VE & GENERAL         5. 00           7. 00         07300 DEKEMTION OF PLANT         5. 00           8. 00         00600 LAUNDRY & LINEN SERVICE         9. 00           9. 00         007000 DEFARAY         11.00           11.00         011000 DETARY         11.00           11.00         011000 CETRARY         11.00           11.00         011000 CETRARY         11.00           11.00         011000 CETRARY         11.00           11.00         011000 MEDI CALL RECORDS & LIBRARY         11.00           11.00         011000 MEDI CALL RECORDS & CETTERS         0           0.00         03000 ADULTS & PEDI ATRICS         0         2.644, 194           50. 00         05400 REDI CALL RECORDS & CETTERS         30.00           0.00         005400 READI (ARCONT CALL RECORDS CETTERS         50.00           54.00         05400 RADI (ARCONT NEW         0         2.644, 194           54.00         05400 RADI (ARCONT NEW         0         2.644, 22         60.00           64.00 DESCONT RADI (ARCONT NEW         0         2.664, 485         54.00         66.00           64.00 SADI (ARL RECORD NEW         0         2.66, 485         54.00         66.00         60.00         60.0						
7. 00         00700 0PERATION OF PLANT         7. 00           8. 00         06800 LAURDRY & LINEN SERVICE         9. 00           0. 00         01000 CAFETERIA         8. 00           11. 00         01100 CAFETERIA         11. 00           13. 00         01400 CAFETERIA         11. 00           13. 00         01400 CENTRAL SERVICE & SUPPLY         11. 00           16. 00         01400 CENTRAL SERVICE & SUPPLY         15. 00           16. 00         01400 CENTRAL RELEWORDS & LIBRARY         16. 00           01400 CHARDICAL RELEWORD & COST CENTRES         30. 00           03100 INTENSI VE CARE UNIT         0         5. 646, 753           30. 00         030300 INTENSI VE CARE UNIT         0         2. 766, 4465           50. 00         05000 OPERATING ROOM         51. 102         56. 00           54. 00         5600 CHARDICACE ODST CENTRES         51. 102         56. 00           50. 00         65000 OPERATING ROOM         1. 440, 828         54. 00           50. 00         66000 OPERSITING ROOM         1. 440, 828         56. 00           50. 00         66000 OPERSITING ROOM         1. 440, 828         56. 00           50. 00         66000 OPERSITING ROOM         1. 440, 828         56. 00           50						
0.00         000000 LAUMDRY & LINEN SERVICE         8.00           0.00         000000 DIESEKEPING         9.00           10.00         01000 DIESEKEPING         9.00           11.00         01000 DIESEKEPING         11.00           11.00         01000 DIESEKEPING         20.00           0.00         00000 DIESEKEPING         0         24.3 982           0.00         00000 DIESEKEPING         0         2.464.194         50.00           50.00         05000 DESEKERENTING         0         2.464.194         54.00           50.00         05000 DESEKERENTING         0         2.464.194         56.00           50.00         05000 DESEKERENTING         0         2.496.973         56.00           50.00         05000 DESEKERENTING         0         2.969.973         56.00           50.00         05000 DIESEKERENTING						
9 0.00 00000 HOUSEKEEPING 00100 CAFETRIA 11.00 11.00 01100 CAFETRIA 11.00 11.00 01100 CAFETRIA 11.00 11.00 11.00 014.00 CENTRAL SERVICE & SUPPLY 11.00 11.00 014.00 CENTRAL SERVICE & SUPPLY 15.00 15.00 01500 MEDICAL RECORDS & LIBRARY 15.00 01500 MEDICAL RECORDS & LIBRARY 15.00 01500 MEDICAL RECORDS & LIBRARY 15.00 03000 ADULTS & PEDIATRICS 00 03000 ADULTS & PEDIATRICS 00 000 OPENATING TRUTH VERSERVICE COST CENTERS 00.00 03000 ADULTS & PEDIATRICS 00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 055.00 055.00 055.00 055.00 055.00 055.00 055.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.00 057.0						
10.00         01000         DETRAY         10.00           11.00         01000         CAFETER IA         11.00           13.00         01300         NURSI NG ADMINISTRATION         13.00           14.00         01400         CHIRRAT CENTREL SERVICE & SUPPLY         15.00           15.00         01500         PHARMACY         16.00           10.00         0000         COUNDED CAL RECORDS & LIBRARY         16.00           10.00         03100         REAT FENT ROUTINE SERVICE COST CENTERS         31.00           00         03000         DUTSS & PEOL RATICS         0         2.43, 982           50.00         05000         OFFECH PATINE KOM         0         2.848, 194         50.00           54.00         DSGOO OFFECH TINK ROM         0         2.848, 194         50.00         54.03           54.00         DSGOO OFFECH PATINER PACED RED BLOOD CELLS         0         4.663, 242         60.00           50.00         DESPECH PATINGAY TREAPY         0         2.896, 973         66.00           60.00         OFFOO OTCUPATIONAL THERAPY         0         0         66.00           70.00         OTOO DUTSO CHARGED TO PATIENTS         0         71.00         76.00           70.00         <						
11.00       01100       CAFETRIA       11.00         13.00       01300       NIRSI KG AMMI STRATION       13.00         14.00       01400 CENTRAL SERVICE & SUPPLY       14.00         15.00       01500 MEDI CAL, RECORDS & LIBRARY       16.00         INPARTENT ROUTINE SERVICE COST CENTERS       30.00       30.00         10.00       03000 ADULTS & PEDI ATRICS       0       5.646,753       30.00         10.00       03000 OPERATI ING ROM       0       2.848,194       50.00         0.00       05000 OPERATI ING ROM       0       2.766,485       54.00         54.00       05400 RESPIRATING ROM       0       2.948,194       50.00         60.00       06600 LABORATORY       0       4.465,242       60.00         65.00       06500 RESPIRATION THERAPY       0       2.96,973       66.00         66.00       06600 UPHYSICA. THERAPY       0       0       66.00         71.00       0100 OTOL MULES ALED TO PATIENT       0       0       66.00         72.00       073.00       07400 DELOGA. SPRICED TO PATIENT       0       71.00       71.00         73.00       07200 DIABORATIONAL THERAPY       0       0       66.00       66.00       66.00       66.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
13.00       01300       NUEN IGA ADMINISTRATION       13.00         14.00       01400       CENTRAL SERVICE & SUPPLY       14.00         15.00       01500       PHARMACY       15.00         10.00       1000       DISOD (PHARMACY       15.00         10.00       01500       PHARMACY       16.00         10.00       03100       INPARTENT ROUTINE SERVICE COST CENTERS       30.00         00.01       03100       INPARTENT ROUTINE SERVICE COST CENTERS       30.00         00.01       03100       INPARTING ROOM       0       2.488.194       50.00         50.00       05000       OFARTING ROOM       0       2.486.542       60.00         61.00       0.00       AROLLARY SERVICE AL INGROSTIC       0       2.766.485       54.00         50.00       05000       IARONTY       0       4.465.242       60.00         62.00       06200       IHADICINAL THERAPY       0       2.996.973       66.00         65.00       06600       PSECH PATHOLOCY       0       0       67.00       69.00         71.00       0700 MEDI CAL, SUPPLIES CHARGED TO PATIENTS       0       17.5866       72.00       73.00       67.00       69.00       73.00       67.						
15.00       01500       PHARMACY       15.00         10.00       1000       1000       1000       1000         10.01       0100       0100       1000       1000       1000         10.01       0100       0100       0100       0100       1000       1000       1000         10.01       0100       0100       0100       0100       0100       1000       1000       1000       1000       1000       1000       1000       1000       1000       1000       1000       1000       1000       1000       1000       1000       10000       10000       10000       10000       10000       10000       10000       10000       10000       10000       100000       100000       100000       100000       100000       100000       100000       100000       100000       100000       1000000       1000000       1000000       1000000       1000000       100000000       1000000000       1000000000000000000000000000000000000						13.00
16:00       01600 MEDICAL RECORDS & LIBRARY       16:00         10:00       03000 ADULTS & PEDIATRICS       0       5,646,753       30:00         30:00       03000 OPERATI NE SERVICE COST CENTERS       30:00       30:00       30:00         ANCILLARY SERVICE COST CENTERS       0       2,766,485       56:00       56:00         50:00       05:000 PERATI NE ROM       0       2,766,485       56:00       56:00         50:00       00:000 PERATI NEDICAR PEDIATROS       0       4,465,242       56:00       56:00         50:00       00:000 UNDERS FLOD & PACKED RED BL000 CELLS       0       51:102       66:00       66:00         60:00       00:000 ON UNLE SERVICE TRATORY THERAPY       0       1,240,282       66:00       66:00         60:00       00:000 OPHYSI CAL THERAPY       0       0       67:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       6	14.00 01400 CENTRAL SERVICE & SUPPLY					14.00
INPATI ENT NOUTINE SERVICE COST CENTERS         Image State						
30. 00         00000 ADULTS & PEDIATRICS         0         5, 646, 753         30. 00           31. 00         0000 INTENSIVE CARE UNIT         0         2, 848, 194         50. 00           30. 00         000 OPERATINE CARE UNIT         0         2, 848, 194         50. 00           30. 00         000 OPERATINE COST CENTERS         54. 00         54. 00         54. 00           54. 00         05400 RADIOLOGY-DIAGNOSTIC         0         2, 27.66, 485         54. 00           54. 00         05400 LABORATORY         0         4, 465, 242         66. 00           60. 00         0000 CLEDRIATORY         0         4, 465, 242         66. 00           60. 00         0000 CLEDRIATORY THERAPY         0         1, 240, 282         66. 00           66. 00         0600 SPESCH PATHOLOCY         0         0         66. 00           67. 00         000 CLEDRIATORATORY         0         0         67. 00           68. 00         06800 SPEECH PATHOLOCY         0         0         67. 00           70. 00         000 ELECTROCATROLIDLOGY         0         0         72. 00           70. 00         000 ELECTROCATROLIDLOGY         0         0         73. 00           71. 00         00000 ELECTROCATROLIDLOGY						16.00
13.0.0         D31.0.0         D31.0.0 <thd31.0.0< th=""> <thd31.0.0< th=""> <thd3< td=""><td></td><td></td><td>F ( 4 ( 750</td><td></td><td></td><td></td></thd3<></thd31.0.0<></thd31.0.0<>			F ( 4 ( 750			
ANCILLARY SERVICE COST CENTRES           ANCILLARY SERVICE COST CENTRES           00         05400 (PADATINE ROOM         0         2, 848, 194         54, 00           54.03         05400 (PADATINE ROOM         0         2, 764, 445         54, 03           54.03         05401 NUCLEAR MEDICINE-DIAGNOSTIC         0         2, 764, 445         54, 03           60.00         DAGOO (LABORATORY         0         4, 465, 242         60, 00           62.00         DACOO (RESPI RATORY THERAPY         0         1, 240, 282         65, 00           66.00         DESDI RESPI RATORY THERAPY         0         2, 866, 973         66, 00           67.00         DOCO OCCUPATIONAL THERAPY         0         0         67, 00           67.00         DOCO OCCUPATIONAL THERAPY         0         0         68, 00           69.00         DOSOD ELECTROCANDIOLOGY         0         0         68, 00           71.00         DICIAL SUPPLIES CHARGED TO PATIENT         0         175, 856         72, 00           72.00         DOSOD INPL. DEV, CHARGED TO PATIENTS         0         175, 856         72, 00           73.00         DTADES CHARGED TO PATIENTS         0         175, 856         72, 00           70.00         DOSOD INPL.						
50.00         05000         0FERATING ROOM         0         2.848, 194         50.00           54.00         36400         RADIOLOGY-DIAGNOSTIC         0         2.766, 485         54.00           54.01         MUCLEAR MEDICINE-DIAGNOSTIC         0         2.21, 938         54.00           60.00         06000         LABORATORY         0         4, 4655, 242         60.00           62.00         05200         WEDICINETRAPY         0         1, 2.240, 282         65.00           66.00         06600         PHYSICAL THERAPY         0         2, 896, 973         66.00           66.00         06600         SPECEL PATHOLOGY         0         0         67.00         67.00           66.00         06600         SPECEL PATHOLOGY         0         0         0         67.00         66.00           66.00         06900         SPECEL PATHOLOGY         0         0         0         67.00         67.00         67.00         67.00         67.00         68.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00		0	243, 982			31.00
54:00       05400       RADIOLOGY-DIAGNOSTIC       0       2,766,485       54.03         54:03       05401       NUCLEAR MEDI CINE-DI AGNOSTIC       0       221,938       54.03         60:00       06000       LABORATORY       0       4,465,242       60.00         62:00       06200       RESPI RATORY THERAPY       0       1,240,282       65.00         66:00       06600       RESPI RATONAL THERAPY       0       2,896,973       66.00         67:00       06700       OCOYO CCUPATI ONAL THERAPY       0       0       67.00         67:00       06000       LELETROCARDI OLOGY       0       0       68.00       69.00         69:00       06900       GEORO FLOCARDI OLOGY       0       0       68.00       69.00         71:00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       961,782       71.00       72.00         73:00       07300       DRAGED TO PATIENTS       0       4,783,271       73.00       73.00         76:00       0548.40       88.01       90.01       1,666,305       88.01       90.02         90:01       09000       CLINIC       0       1,828       90.02       90.02       90.02       90.02		0	2 848 194			50.00
54.0       05401       MUCLEAR MEDICINE-DIAGNOSTIC       0       221,938       54.03         60.00       06000       LABORATORY       0       4.465,242       60.00         62.00       06200       MEDICINE-DIAGNOSTIC       0       1,40,282       65.00         66.00       06500       RESPIRATORY THERAPY       0       1,240,282       65.00         66.00       06000       SPECE HATHORY THERAPY       0       0       66.00         66.00       06000       SPECE HATHORY THERAPY       0       0       66.00         66.00       06000       SPECE HATHOLOGY       0       0       67.00       68.00         69.00       06900       SPECE HARGED TO PATIENTS       0       961,782       71.00       72.00         70.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       175,856       72.00       73.00         76.00       03800       RUKAL HEALTH CLINIC       0       158,440       88.00       88.00         88.01       08800       RUKAL HEALTH CLINIC       0       158,433       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00						
62:00       06200       HINLE BLOOD & PACKED RED BLOOD CELLS       0       51,102       62.00         65:00       06500       RESPIRATORY THERAPY       0       1,240,282       65.00         66:00       06600       PHYSICAL THERAPY       0       0       66.00         66:00       06600       PHYSICAL THERAPY       0       0       67.00         68:00       06600       SPECEL PATHOLOGY       0       0       68.00         68:00       0600       SUPECLE PATHOLOGY       0       0       68.00         69:00       0700       NEDICAL SUPPLIES CHARGED TO PATIENTS       0       175,856       72.00         73:00       07300       DRUGS CHARGED TO PATIENTS       0       175,856       72.00         70:00       000       00010       SPECH PATHOLOGY       0       394,804       76.00         00       0800 RURAL HEALTH CLINIC I       0       1,666,305       88.01       90.00         90:01       09001 CLINIC       0       1,41,154       90.02       90.02         90:02       09002 OP PSYCH       0       1,267,374       90.02         90:03       90000       92.00       09200 OBSERVATION BEDS (NON-DISTINCT PART       0 <td< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td></td<>		0				
65.00       06500       RESPI RATORY THERAPY       0       1, 240, 282       65.00         66.00       06600       PHYSI CAL THERAPY       0       2, 896, 973       66.00         67.00       06700       DCCUPATI ONAL THERAPY       0       0       67.00       66.00         68.00       DECENCARDI OLOGY       0       0       0       67.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       71.00       72.00       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       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       73.00       73.00       73.00       73.00 <td>60. 00 06000 LABORATORY</td> <td>0</td> <td>4, 465, 242</td> <td></td> <td></td> <td>60.00</td>	60. 00 06000 LABORATORY	0	4, 465, 242			60.00
66.00         06/00         06/00         06/00         06/00         06/00         06/00         06/00         06/00         06/00         06/00         0         66.00         67.00         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         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	51, 102			
67.00       06700       OCCUPATIONAL THERAPY       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       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       0       0       0       0       0       0       0       0       0       0 <td< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td></td<>		0				
68.00         06800         SPECH PATHOLOGY         0         0         68.00         68.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         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         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         <		0				
69.00         06900         ELECTROCARDIOLOGY         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         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 <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		0				
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       961,782       71.00         72.00       07200       INPL. DEV. CHARGED TO PATIENTS       0       175,856       72.00         73.00       07300       DRUSC CHARGED TO PATIENTS       0       394,804       76.00         0017001       INFUSION THERAPY       0       394,804       76.00         0017001       D0800       RURAL HEALTH CLINIC       0       1,666,305       88.01         80.00       08801       RURAL HEALTH CLINIC       0       1,666,305       90.01         90.00       09000       CLINIC       0       1,828       90.01         90.01       09002       PSYCH       0       0       90.02         90.02       09002       PSYCH       0       0       90.02         90.03       09003       PAIN MAAGEMENT       0       584,335       90.02         90.00       09200       08SERVATION BEDS (NON-DI STINCT PART       0       1,267,374       91.00         91.00       92.00       09200       08SERVATION BEDS (CONT CENTERS       113.00       118.00       113.00       114.05         91.00       SUBTOTALS (SUM OF LINES 1 through 117)       0       36,		0				
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       175,856       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       4,783,271       73.00         76.00       3360 I NUFLS ION THERAPY       0       394,804       76.00         0UTPATIENT SERVICE COST CENTERS       9       88.00       0800 RURAL HEALTH CLINIC       0       958,440       88.00         88.01       0800 RURAL HEALTH CLINIC II       0       1.666,305       88.01       90.00         90.01       09001 CLINIC       0       1.828       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.03       91.00       90.02       90.02       90.03       91.00       90.03       91.00       90.03       91.00       90.03       91.00       92.00       9200       082KNATION BEDS (NON-DISTINCT PART       0       1.267,374       101.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.		0	-			
73.00       07300       DRUGS CHARGED TO PATIENTS       0       4, 783, 271       73.00         76.00       03480       INFUSION THERAPY       0       394, 804       76.00         00       000       CONTPATIENT SERVICE COST CENTERS       88.00       88.00       88.01       88.00       88.01       0800       RURAL HEALTH CLINIC       0       1, 666, 305       88.01       90.01       90.00       11.11, 154       90.00       90.01       90.01       90.01       90.01       90.02       0PSYCH       0       1, 828       90.01       90.02       90.02       0PSYCH       0       14, 776, 889       90.02       90.02       90.02       0PSYCH       0       4, 776, 889       90.03       90.03       90.03       91.00       90.02       0PSOUD EMERGENCY       0       4, 776, 889       90.02       90.02       90.02       90.03       90.03       90.03       91.00       91.00       92.00       0BSERVATION BEDS (NON-DI STINCT PART       0       4, 776, 889       90.03       90.03       91.00       90.03       91.00       91.00       91.00       91.00       91.00       91.00       91.00       91.00       91.00       91.00       91.00       91.00       91.00       91.00       91.00       91.0		0				
76.00       03480       INFUSION THERAPY       0       394,804       76.00         0UTPATIENT SERVICE COST CENTERS       0       958,440       88.00       88.01         8.00       08800       RURAL HEALTH CLINIC       0       1,666,305       88.01         90.01       09000       CLINIC       0       1,41,154       90.00         90.01       09000       CLINIC       0       1,828       90.01         90.02       09002       OP SYCH       0       0       90.02         90.03       09003       PAIN MANAGEMENT       0       584,335       90.03         91.00       09020       OBEREVATION BEDS (NON-DISTINCT PART       0       4,776,889       92.00         01100       HOME HEALTH AGENCY       0       1,267,374       91.00         92.00       09200 DESERVATION BEDS (NON-DISTINCT PART       0       13.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       194.00       194.01       194.01       194.01       194.01       194.01       194.01       194.01       194.02 <t< td=""><td></td><td>-</td><td></td><td></td><td></td><td></td></t<>		-				
88.00       08800       RURAL HEALTH CLINIC       0       958,440       88.00         88.01       08801       RURAL HEALTH CLINIC II       0       1,666,305       90.00         90.00       09000       CLINIC       0       141,154       90.00         90.01       09000       CLINIC       0       141,154       90.00         90.02       09000       CLINIC       0       141,154       90.01         90.02       09000       CLINIC       0       0       90.02         90.03       09003       PAIN MANAGEMENT       0       584,335       90.03         91.00       09100       EKERGENCY       0       4,776,889       91.00         92.00       OBSERVATION BEDS (NON-DISTINCT PART       0       1,267,374       92.00         01100       HOME HEALTH AGENCY       0       1,267,374       101.00         113.00       I1300 INTEREST EXPENSE       113.00       1130.00       11300 INTEREST EXPENSE       113.00         113.00       SUBTOTALS (SUM OF LINES 1 through 117)       0       36,092,989       113.00         194.00       07950 MOB       0       4,227,156       194.02         194.02       07952 ASC       0		0				
88.01       08801       RURAL HEALTH CLINICII       0       1,666,305       88.01         90.00       09000       CLINIC       0       141,154       90.00         90.01       09001       DI ABETES       0       1,828       90.01         90.02       0P PSYCH       0       0       0       90.02         90.03       09003       PAIN MANAGEMENT       0       584,335       90.03         91.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0       4,776,889       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0       1,267,374       91.00         01.00       HOME HEALTH AGENCY       0       1,267,374       101.00         SPECIAL PURPOSE COST CENTERS         113.00       INTREST EXPENSE       113.00       113.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       0       36,092,989       118.00         194.00       O7951       FOUNDATI ON       0       132,379       194.00         194.02       O7952       ASC       0       0       194.02         194.03       O7953       SNF - PERRY CO.       0       0       194.03		TT		-		
90.00       09000       CLINIC       0       141,154       90.00         90.01       09001       DIABETES       0       1,828       90.01         90.02       09002       OP PSYCH       0       0       90.02         90.03       09003       PAIN       MAAAGEMENT       0       584,335       90.03         91.00       09100       EMERGENCY       0       4,776,889       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DISTINCT PART       0       1,267,374       92.00         OTHER REIMBURSABLE COST CENTERS         101.00       10100       HMERSABLE COST CENTERS       91.00         113.00       11300       INTEREST EXPENSE       113.00         SUBTOTALS (SUM OF LINES 1 through 117)       0       36,092,989       118.00         NONREI MBURSABLE COST CENTERS         194.00       7950       MOB       0       4,227,156       194.00         194.01       07951       FOUNDATI ON       0       132,379       194.01       194.02         194.02       07952       ASC       0       0       194.03       194.03       194.03         194.04       <		-				
90. 01       09001       DI ABETES       0       1, 828       90. 01         90. 02       09002       0P PSYCH       0       0       90. 02         90. 03       09003       PAI N MANAGEMENT       0       584, 335       90. 03         91. 00       09100       EMERGENCY       0       4, 776, 889       91. 00         92. 00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       92. 00       92. 00         OTHER REI MBURSABLE COST CENTERS         101. 00       10100 HOME HEALTH AGENCY       0       1, 267, 374       101. 00         SPECI AL PURPOSE COST CENTERS         113. 00       11300 I INTEREST EXPENSE       113. 00         113.00 O 11300 I INTEREST EXPENSE       113. 00         NONREL MBURSABLE COST CENTERS         194. 00 07950 MOB       0       4, 227, 156         194. 00 07950 MOB       0       132, 379       194. 01         194. 02       07952 ASC       0       0       194. 02         194. 03       07953 SNF - PERRY CO.       0       0       194. 03         194. 04       07954 TELE BHAVI ORAL       0       0       194. 03		U U				
90. 02         09 002         0P PSYCH         0         0         90. 02         90. 02         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         90. 03         91. 00         91. 00         91. 00         91. 00         92. 00         91. 00         92. 00         91. 00         92. 00         91. 00         92. 00         91. 00         91. 00         91. 00         91. 00         91. 00         91. 00         91. 00         91. 00         91. 00         91. 00         91. 00         91. 00		0				
90.03       09003       PAIN MANAGEMENT       0       584,335       90.03         91.00       09200       DBERVATION BEDS (NON-DISTINCT PART       0       4,776,889       91.00         0200       DBSERVATION BEDS (NON-DISTINCT PART       0       1,267,374       92.00         01000       HOME HEALTH AGENCY       0       1,267,374       101.00         SPECIAL PURPOSE COST CENTERS       113.00       INTEREST EXPENSE       113.00         113.00       INTEREST EXPENSE       113.00       11300       INTEREST EXPENSE       113.00         194.00       07950       MOB       0       4,227,156       194.00         194.01       07951       FOUNDATION       0       132,379       194.01         194.02       07952       ASC       0       0       194.02       194.02         194.04       07953       SNF - PERRY CO.       0       0       194.02       194.03       194.03       194.03       194.03       194.03       194.03       194.03       194.03       194.03       194.03       194.03       194.03       194.03       194.03       194.03       194.04       194.04       194.04       194.04       194.04       194.04       194.04       194.04 <t< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td></t<>		0				
91.00       09100       EMERGENCY       0       4,776,889       91.00         92.00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART       0       92.00         0THER       REIMBURSABLE COST CENTERS       0       1,267,374       101.00         101.00       10100       HOME HEALTH AGENCY       0       1,267,374       101.00         SPECIAL PURPOSE COST CENTERS         113.00       INTEREST EXPENSE       113.00       11300       INTEREST EXPENSE       113.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       0       36,092,989       118.00       118.00         194.01       07950       MOB       0       4,227,156       194.00       194.01         194.02       07952       ASC       0       0       194.02       194.02         194.02       07952       ASC       0       0       194.02       194.02         194.04       07954       FULE BEHAVI ORAL       0       0       194.03       194.03       194.03       194.03         194.04       07954       TELE BEHAVI ORAL       0       0       194.03       194.03       194.03       194.03         194.04       07954       TELE BEHAVI ORAL		0	-			
92.00       09200       0BSERVATION BEDS (NON-DISTINCT PART       0       92.00         0THER REIMBURSABLE COST CENTERS       0       1,267,374       101.00         101.00       10100       HOME HEALTH AGENCY       0       1,267,374       101.00         SPECIAL PURPOSE COST CENTERS         113.00       11300       INTEREST EXPENSE       113.00       11300         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       0       36,092,989       118.00         194.00       07950       MOB       0       4,227,156       194.00         194.01       07951       FOUNDATION       0       132,379       194.01         194.02       07952       ASC       0       0       194.02         194.03       07953       SNF - PERRY CO.       194.03       194.03         194.04       07954       TELE BEHAVI ORAL       0       0       194.03         194.04       07953       SNF - PERRY CO.       194.03       194.03       194.03         194.04       07954       TELE BEHAVI ORAL       0       0       194.03         194.04       07954       TELE BEHAVI ORAL       0       0       194.04         00       0		Ŭ				
101.00         HOME         HEALTH         AGENCY         0         1, 267, 374         101.00           SPECIAL         PURPOSE         COST         CENTERS         113.00         113.00         1NTEREST         EXPENSE         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         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         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         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         114.00         104.00         104.00         104.00         104.00         104.00         104.00         104.00         104.00         104.00         104.00         104.00         104.00         104.00         104.00         104.00         104.03         104.03         104.03         104.03 <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		0				
SPECIAL PURPOSE COST CENTERS           113.00         INTEREST EXPENSE         113.00           SUBTOTALS (SUM OF LINES 1 through 117)         0         36,092,989         118.00           NONREI MBURSABLE COST CENTERS         114.00         118.00         118.00           194.00         07950         MOB         0         4,227,156         194.00           194.01         07951         FOUNDATI ON         0         132,379         194.01           194.02         07952         ASC         0         0         194.02           194.03         07953         SNF - PERRY CO.         194.02         194.03         194.04           194.04         07954         TELE         BEHAVI ORAL         0         0         194.04           200.00         Cross Foot Adj ustments         0         0         200.00         201.00	OTHER REIMBURSABLE COST CENTERS					
113.00       11300       INTEREST EXPENSE       113.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       0       36,092,989       118.00         NONREI MBURSABLE COST CENTERS         194.00       07950       MOB       0       4,227,156       194.00         194.01       07951       FOUNDATI ON       0       132,379       194.01         194.02       07952       ASC       0       0       194.02         194.03       07953       SNF - PERRY CO.       0       0       194.02         194.04       07954       TELE BEHAVI ORAL       0       0       194.04         200.00       Cross Foot Adj ustments       0       0       200.00       201.00		0	1, 267, 374			101.00
I18.00         SUBTOTALS (SUM OF LINES 1 through 117)         0         36,092,989         118.00           NONREI MBURSABLE COST CENTERS         194.00         7950         MOB         194.00         194.00         194.00         194.00         194.00         194.00         194.00         194.00         194.00         194.00         194.00         194.00         194.00         194.00         194.00         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.02         194.03         194.04         194.02         194.03         194.04         194.03         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04						
NONREI MBURSABLE COST CENTERS         194.00         07950         MOB         194.00         194.00         194.00         194.00         194.00         194.00         194.00         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.02         194.02         194.03         194.03         194.03         194.03         194.03         194.03         194.03         194.03         194.03         194.03         194.03         194.03         194.03         194.03         194.04         194.04         194.04         194.03         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04         194.04						
194.00       07950       MOB       0       4, 227, 156       194.00         194.01       07951       FOUNDATI ON       0       132, 379       194.01         194.02       07952       ASC       0       0       194.02         194.03       07953       SNF - PERRY CO.       0       0       194.03         194.04       07954       TELE BEHAVI ORAL       0       0       194.03         200.00       Cross Foot Adjustments       0       0       200.00       201.00		0	36, 092, 989			118.00
194.01       07951       FOUNDATI ON       0       132, 379       194.01         194.02       07952       ASC       0       0       194.02         194.03       07953       SNF - PERRY CO.       0       0       194.03         194.04       07954       TELE BEHAVI ORAL       0       0       194.04         200.00       Cross Foot Adjustments       0       0       200.00       201.00		0	4 227 156			194 00
194.02       07952       ASC       0       0       194.02         194.03       07953       SNF - PERRY CO.       0       0       194.03         194.04       07954       TELE BEHAVI ORAL       0       0       194.04         200.00       Cross Foot Adjustments       0       0       200.00       200.00         201.00       Negative Cost Centers       0       0       201.00		0				
194.03       07953       SNF - PERRY CO.       0       0       194.03         194.04       07954       TELE BEHAVI ORAL       0       0       194.04         200.00       Cross Foot Adjustments       0       0       200.00       200.00         201.00       Negative Cost Centers       0       0       201.00		0	.02,077			
194.04         07954         TELE BEHAVI ORAL         0         0         194.04           200.00         Cross Foot Adjustments         0         0         200.00           201.00         Negative Cost Centers         0         0         201.00		o	0			
201.00         Negative Cost Centers         0         0         201.00	194. 04 07954 TELE BEHAVI ORAL	0	0			194.04
		0	0			
202.00   [10TAL (sum lines 118 through 201)   0 40,452,524 202.00			0			
	202.00   IUTAL (sum lines 118 through 201)	0	40, 452, 524			202.00

Health Financial Systems	DEACONESS	GIBSON		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	F	eriod: rom 10/01/2020 o 09/30/2021	Worksheet B Part II	pared:
Cost Center Description	Di rectl y Assi gned New Capi tal Rel ated Costs O	CAPI TAL RELATED COSTS BLDG & FI XT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT 4.00	ADMI NI STRATI V E & GENERAL 5. 00	
GENERAL SERVICE COST CENTERS	0	1.00	27	4.00	5.00	
1.00         00100         CAP         REL         COSTS-BLDG         & FIXT           4.00         00400         EMPLOYEE         BENEFITS         DEPARTMENT           5.00         00500         ADMINISTRATIVE         & GENERAL           7.00         00700         OPERATION         OF         PLANT           8.00         00800         LAUNDRY         & LINEN         SERVICE	0 0 0 0	21, 134 133, 261 668, 387 43, 495	21, 134 133, 261 668, 387 43, 495	2, 537 345 110	135, 798 11, 877 649	1.00 4.00 5.00 7.00 8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CE & SUPPLY 15. 00 01500 PHARMACY		24, 549 30, 153 81, 520 7, 365 0 35, 810	24, 549 30, 153 81, 520 7, 365 0 35, 810	148 397 157 233	2, 571 1, 120 1, 872 957 1, 036 15, 408	13.00 14.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY INPATI ENT ROUTI NE SERVI CE COST CENTERS	0	35, 570	35, 570	176	1, 193	
30.00         O3000         ADULTS         & PEDI ATRICS           31.00         03100         INTENSI VE CARE UNI T	0	244, 534 51, 661	244, 534 51, 661	3, 287 27	13, 390 326	30.00 31.00
ANCI LLARY SERVI CE COST CENTERS           50.00         05000         OPERATI NG ROOM           54.00         05400         RADI OLOGY-DI AGNOSTI C           54.03         05401         NUCLEAR MEDI CI NE-DI AGNOSTI C           60.00         06000         LABORATORY           62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CEI           65.00         06500         RESPI RATORY THERAPY           66.00         06600         PHYSI CAL THERAPY           66.00         06600         SPECH PATHOLOGY           68.00         06600         SPECH PATHOLOGY           69.00         06900         ELECTROCARDI OLOGY           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS           73.00         07300         DRUGS CHARGED TO PATI ENTS           76.00         03480         INFUSI ON THERAPY           0UTPATI ENT SERVI CE COST CENTERS         88.00           88.01         08800         RURAL HEALTH CLI NI C           88.01         08801         RURAL HEALTH CLI NI C           90.01         09001         LI ABETES           90.02         09002         OP SYCH           90.03         09003         PAI N MANAGEMENT           91.00	NT 00 00 00 00 00 00 00 00 00 00 00 00 00	136, 196 93, 288 11, 207 40, 827 0 43, 015 98, 465 0 0 95, 770 0 95, 770 0 0 28, 472 0 38, 425 0 0 38, 425 0 0 42, 028 207, 657	136, 196 93, 288 11, 207 40, 827 0 43, 015 98, 465 0 0 95, 770 0 95, 770 0 28, 472 0 38, 425 0 38, 425 0 0 42, 028 207, 657	1, 612 0 1, 263 0 837 40 0 0 0 0 0 0 0 0 0 0 201 545 1, 219 99 0 0 0 0 208 1, 904	7, 558 7, 653 631 13, 672 169 3, 465 8, 660 0 0 0 2, 090 509 0 992 3, 216 5, 240 428 6 0 1, 520 13, 452	54.03 60.00 62.00 65.00 66.00 67.00 68.00 69.00 71.00 72.00 73.00 76.00 88.01 90.00 88.01 90.01 90.01 90.03 91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PAI OTHER REI MBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	RT 0	13, 476	0		3, 924	92.00 101.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through						113.00
Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure         Instructure		188, 631 34, 930 0 0 0	188, 631 34, 930 0 0 0 0 0 0 0	2, 236 0 0 0 0 0	12, 086 128 0 0 0 0	194.00 194.01 194.02 194.03 194.04 200.00 201.00

Health Financial Systems	DEACONESS	GIBSON		In Lieu	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: com 10/01/2020 o 09/30/2021	Worksheet B Part II Date/Time Pre 2/28/2022 10:	
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						
1.00       00100       CAP_REL_COSTS-BLDG & FIXT         4.00       00400       EMPLOYEE BENEFITS DEPARTMENT         5.00       00500       ADMI NI STRATI VE & GENERAL         7.00       00700       OPERATION OF PLANT         8.00       00800       LAUNDRY & LI NEN SERVI CE         9.00       00900       HOUSEKEEPI NG         10.00       01000       DI ETARY         11.00       01100       CAFETERI A         13.00       01300       NURSI NG ADMI NI STRATI ON         14.00       01400       CENTRAL_SERVI CE & SUPPLY	680, 609 18, 195 10, 269 12, 613 34, 101 3, 081 0	62, 449 0 0 0 0 0 0	37, 860 732 1, 980 179 0	44, 766 0 0 0		13.00 14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY	14, 980 14, 879	0	870 864	0	2,901	15.00 16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	14,079	0	004	U	1, 377	10.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSI VE CARE UNI T	102, 292 21, 610	61, 916 533		44, 384 382	25, 640 209	
ANCI LLARY SERVICE COST CENTERS			r			
50. 00 05000 OPERATING ROOM	56, 972	0	3, 307	0	15, 289	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	39, 023	0	2, 265	0	12, 577	•
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	4, 688	0	272 991	0	0 050	
60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	17, 078 0	0	991	0	9, 858 0	60.00 62.00
65. 00 06500 RESPIRATORY THERAPY	17, 994	0	1,045	0	6, 529	65.00
66. 00 06600 PHYSI CAL THERAPY	41, 189	0	2, 391	0	309	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	41, 107	0	2, 371	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
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	40, 061	0	2, 326	0	0	
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
76.00 03480 INFUSION THERAPY	11, 910	0	691	0	1, 568	76.00
OUTPATIENT SERVICE COST CENTERS				i		
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	
88.01 08801 RURAL HEALTH CLINIC II	16, 074	0	933	0	0	88.01
90. 00 09000 CLINIC	0	0	0	0	769	•
90. 01 09001 DI ABETES 90. 02 09002 0P PSYCH	0	0	0	0	0	90.01 90.02
90. 03 09003 PALN MANAGEMENT	17, 581	0	1, 021	0	1, 626	
91. 00 09100 EMERGENCY	86, 865	0	5, 043	0	14,859	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	00,000	0	0,010	Ŭ	11,007	92.00
OTHER REIMBURSABLE COST CENTERS				1		1
101.00 10100 HOME HEALTH AGENCY	5, 637	0	327	0	5, 861	101.00
SPECIAL PURPOSE COST CENTERS						1
113.0011300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117	) 587,092	62, 449	32, 431	44, 766	102, 419	118.00
NONREI MBURSABLE COST CENTERS						
194. 00 07950 MOB	78, 906	0	4, 581	0		194.00
194. 01 07951 FOUNDATI ON	14, 611	0	848	0		194.01
194. 02 07952 ASC 194. 03 07953 SNF - PERRY_CO.	0	0	0	0		194.02 194.03
194. 03 07953 SNF - PERRY CO. 194. 04 07954 TELE BEHAVI ORAL	0	0	0	0		194.03
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	Ο	0	0	0	200.00
202.00 TOTAL (sum lines 118 through 201)	680, 609	62, 449	37, 860	44, 766	119, 870	

	ncial Systems	DEACONESS				u of Form CMS-	2552-10
ALLOCATION (	OF CAPITAL RELATED COSTS		Provider CO	CN: 15-1319	Period: From 10/01/2020	Worksheet B Part II	
					To 09/30/2021	Date/Time Pre 2/28/2022 10:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	
		ADMI NI STRATI O	SERVICE &		RECORDS &		
		N 12.00	SUPPLY	15.00	LI BRARY	24.00	
GENER	AL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	24.00	-
	CAP REL COSTS-BLDG & FIXT						1.00
	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 00900	HOUSEKEEPING						9.00
10.00 01000	DIETARY						10.00
11.00 01100	CAFETERIA						11.00
13.00 01300	NURSING ADMINISTRATION	12, 966					13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	0	3, 089				14.00
15.00 01500	PHARMACY	390	19	70, 7	50		15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0		0 54, 059		16.00
I NPAT	IENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	3, 735	145		0 3, 530	508, 792	30.00
	INTENSIVE CARE UNIT	0	0		0 19	76, 022	31.00
	LARY SERVICE COST CENTERS	,					
	OPERATING ROOM	1, 362	436		0 6, 099	229, 178	
	RADI OLOGY-DI AGNOSTI C	1, 732	97		0 11, 942	170, 189	
	NUCLEAR MEDICINE-DIAGNOSTIC	0	1		0 433	17, 232	
	LABORATORY	1, 357	982		0 9, 931	95, 959	
	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 96	265	
	RESPI RATORY THERAPY	871	37		0 2, 916	76, 709	
	PHYSI CAL THERAPY	0	28		0 5, 487	156, 569	
	OCCUPATIONAL THERAPY	0	0		0 0	0	
	SPEECH PATHOLOGY	0	0		0 0	0	
	ELECTROCARDI OLOGY	0	0		0 0	0	
	MEDICAL SUPPLIES CHARGED TO PATIENT	0	777		0 0	141, 024	
	IMPL. DEV. CHARGED TO PATIENTS	0	233		0 0	742	
	DRUGS CHARGED TO PATIENTS	0	0	70, 7		78, 082	
	INFUSION THERAPY	221	38		0 361	44, 454	76.00
	TI ENT SERVICE COST CENTERS		4	[		2.7/5	00.00
	RURAL HEALTH CLINIC	0	4		0 0	3, 765	1
	RURAL HEALTH CLINIC II	0 109	16		0 0 0 288	61, 907	
	DIABETES	0	34 0			1, 727	
	OP PSYCH	0	-		0 6 0 0	12	
		233	0 5		0 173	0 64 205	
		233	5 155			64, 395 337, 480	
	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	2,099	100		0 5, 446	337,400	
	REIMBURSABLE COST CENTERS						92.00
	HOME HEALTH AGENCY	857	35		0 0	30.868	101.00
	AL PURPOSE COST CENTERS	057	55		0 0	30, 808	
	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	12, 966	3, 042	70, 7	50 54, 059	2, 095, 371	
	IMBURSABLE COST CENTERS	12, 700	5, 042	70,7	50 54,057	2,075,571	
194. 00 07950		0	47		0 0	303, 936	194 00
194.0107951		0	47		0 0		194.00
194. 02 07952		0	0		0 0		194.01
	SNF - PERRY CO.	0	0		0 0		194.02
	TELE BEHAVI ORAL	0	0		0 0		194.03
200.00	Cross Foot Adjustments		0				200.00
201.00	Negative Cost Centers	0	0		0 0		200.00
202.00	TOTAL (sum lines 118 through 201)	12, 966	3, 089	70, 7	50 54, 059	2, 449, 826	
202.00	(Jun Thes no through 201)	12, 700	5,007	10,1	54,054	2, 447, 020	1202.00

ALLOCATION OF CAPITAL RELATED COSTS         Provider COX: 15-1319         Provider COX: 15-131	Heal th Financial	Systems	DEACONESS	GI BSON		In Li	eu of Form CMS-2	2552-10
To         09/30/2021         Data String           Cost Center Description         Littern 6 Registions 2         Total Cost 8 Prost Stipdoon         T	ALLOCATION OF CA	APITAL RELATED COSTS		Provider C	CCN: 15-1319			
Cost Center Description         Intern & Cost Senter         Total           Cost Center Description         Disting to Cost Senter         Total           Cost Senter         Senter         Senter         Senter           BENERAL_SENNCE COST CONTENS         26.00         26.00         100           100         DOTOR PART CONTENS & ELEMENT         25.00         26.00         100           100         DOTOR PART CONTENS & ELEMENT         25.00         26.00         100           5.00         DOSOO AMM INSTRATIVE & CONTENS         6.00         0.0000 DESALDINO PENALT         5.00           0.0000 DESALDINO PENALT         0.0000 DESALDINO PENALT         0.0000 DESALDINO PENALT         10.00           1.000         DIDOS DESALDINO PENALT         0.0000 DESALDINO PENALT         10.00           1.000         DIDOS DESALDINO PENALT         0.0000 DESALDINO PENALT         10.00           1.000         DIDOS DESALDINO PENALT         0.0000 DESALDINO PENALT         10.00           1.000         DIDOS DESALDINO PENALT         0.0000 DESALDINO PENALT         10.000           1.000         DIDOS DESALDINO PENALT         0.0000 DESALDINO PENALT         10.000           1.000         DIDOS DESALDINO PENALT         0.0000 DESALDINO PENALT         10.000           1.00								nared
Desidents         Cost & Post Stepdom         Adv           100         DOTOD CAP FEL, COST CENTERS         33.00         26.00           100         DOTOD APP EL, COST CENTERS         33.00         26.00           100         DOTOD APP EL, COST SUBJOR & FIXT         4.00           400         DOTOD OPENATION OF PLANT         5.00           100         DOTOD OPENATION OF PLANT         7.00           100         DOTOD OPENATION OF PLANT         7.00           11.00         DOTOD OPENATION OF PLANT         7.00           11.00         DOTOD OPENATION OF PLANT         9.00           11.00         DOTOD OPENATION OF PLANT         9.00           11.00         DOTOD OPENATION OF PLANT         11.00           11.00         DOTOD OPENATION FOR SERVICE         9.00           11.00         DOTOD OPENATION FOR SERVICE         9.00           11.00         DOTOD OPENATION FOR SERVICE         9.00           11.00         DOTOD OPENATION FOR PLANTRING         11.00           11.00         DOTOD OPENATION FOR PLANTRING         0.220.178           11.00         DOTOD OPENATION FOR PLANTRING         0.220.178           11.00         DOTOD OPENATION FOR PLANTRING         0.200.020.0000000000000000000000000000					-	10 077 007 202	2/28/2022 10: 0	<u>06 am</u>
Cost & Post Adj ustnonts         Zeo Out           1.00         GIODCAP. PEL COSTS. ELDC. A. FLXT         4.0           0.00         OCSOL PELVOFE ENFETS DE PARTNET         4.0           0.00         OCSOL PELVOFE ENFETS DE PARTNET         4.0           0.00         OCSOL PELVOFE SERVETS DE PARTNET         4.0           0.00         OCSOL PARTNET VE & GENERAL         7.0           0.00         OCSOL PARTNET VE & GENERAL         7.0           0.00         OCSOL PARTNET SE PARTNET         8.00           0.00         OCSOL PARTNET VE & GENERAL         7.0           1.00         CIGAC AFERER A         11.00           1.00         OTSOL PARTNET SE PARTNET         11.00           1.00         OTSOL PARTNET SE PERFORMENCE         11.00           1.00         OTSOL PARTNET SERVICE COST CENTERS         11.00           1.00         OTSOL PARTNET ROUTINE SERVICE COST CENTERS         11.00           1.00         OTSOL PARTNET ROUTINE SERVICE COST CENTERS         11.00           1.00         OTSOL PARTNET ROUTINE SERVICE COST CENTERS         10.00           1.00         OTSOL PARTNET ROUTINE SERVICE COST CENTERS         10.00           1.00         OTSOL PARTNET ROUTINE SERVICE COST CENTERS         10.00           1.00         <	Cost	t Center Description		Total				
Steptom         Justicents         Justicents           0100         CARNEL_SERVICE_COST_CENTERS         1.00           1.00         00100/CAR_REL_COST_CENTERS         1.00           1.00         00100/CAR_REL_COST_CENTERS         1.00           1.00         00100/CAR_REL_COST_SILUS & FIXT         1.00           1.00         00100/CAR_REL_COST_SILUS & FIXT         4.00           1.00         00100/CAR_REL_COST_SILUS & FIXT         5.00           1.00         00100/CAR_REL_COST_SILUS & FIXT         5.00           1.00         00100/CAR_REL_SERVICE         0.00           0.00         00100/CAR_REL_REVERT         0.00           1.00         01400/CAR_REVERT         0.00           1.00         01400/CAR_REVERT         0.00           1.00         01400/CAR_REVERT         0.00           01400/CAR_REVERT         0.00         76.022           01400/CAR_REVERT         0.00         76.022         30.00           01300/INTERSIVE CARE INIT         0         76.022         30.00           01300/INTERSIVE CARE INIT         0         76.022         30.00           01400/CAR_REVERT NOR         0.00         220.7178         54.00           01400/CAR_REVERT NOR         0.00								
Adj usiteents         26.00           BENERAL SERVICE COST CENTERS         1.00           1.00         00100 CAP REL COST GENTENS         1.00           1.00         00100 CAP REL COST GENTENS         4.00           1.00         00100 CAP REL COST GENTENS         4.00           1.00         00100 CAP REL COST GENTENS         7.00           1.00         00100 CAP REL COST GENTENS         7.00           1.00         00100 CAP REL COST GENTENS         7.00           1.00         01000 CAPERATION FALSENVICE         9.00           0.00         00000 CAPTRAL SERVICE         9.00           1.00         01000 CAPTRAL SERVICE         9.00           1.00         01000 CAPTRAL SERVICE COST CENTERS         11.00           1.00         1000 CHEATINE OF REVICE COST CENTERS         9.00           1.00         01000 CHEATINE COST CENTERS         9.00           1.00         03000 CHEATINE ORD NO         0         229, 178           1.00         00000 CHEATINE STORE CAST CENTERS         9.00           1.00         00000 CHEATINE STORE CAST CENTERS         9.00           1.00         01000 CHEATINE STORE CAST CENTERS         9.00           1.00         00000 CHEATINE STORE CAST CENTERS         9.00								
ENERAL SERVICE COST CENTERS         1.00         00100 CAP REL COST S-BLDG A FIXT         1.00           0.00         00500 CAP REL COST S-BLDG A FIXT         4.00         4.00           1.00         00500 CAP REL COST S-BLDG A FIXT         4.00         4.00           1.00         00500 CAP REL COST S-BLDG A FIXT         4.00         4.00           1.00         00500 CAP REL COST S-BLDG A FIXT         4.00         4.00           1.00         00500 CAP REL COST S-BLDG A FIXT         7.00         7.00           1.00         00500 CHUSKEREP ING         7.00         7.00         7.00           10.00         01000 CHERANCEP ING         10.00         13.00         13.00         13.00           11.00         01400 CENTRAL SERVICE & SUPPLY         10.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>								
CRUERAL SERVICE COST CENTRES         1.00           1.00         ODCOOD CAP REL COSTS BLIG & FIXT         4.00           4.00         DOVOD CAP REL COSTS BLIG & FIXT         4.00           4.00         DOVOD CAP REL COSTS BLIG & FIXT         4.00           4.00         DOVOD CAP REL COSTS BLIG & FIXT         5.00           4.00         DOVOD QEENTIN ON OF PLANT         8.00           5.00         DOVOD QEENTING SERVICE         9.00           5.00         DOVOD QEENTING SERVICE         9.00           5.00         DISOD PLANKARY         10.00           113.00         DISOD PLANKARY         11.00           114.00         DISOD PLANKARY         11.00           115.00         DISOD PLANKARY         11.00           116.00         DISOD PLANKARY         11.00           116.00         DISOD PLANKARY         11.00           117.01         0         76, 022           118.00         DISOD QHISA & PEDRING COST CENTERS         0           110.00         DISOD QHISA & PEDRING				26.00	-			
1.00       00100_CAP_REL_COSTS_BLDG & FLXT       1.00         0.00       00500_REMIVECE ENTERS TS DEPARTMENT       4.00         0.00       00500_REMIVECE ENTERS TS DEPARTMENT       5.00         0.00       00600_LAUMORY & LINEN SERVICE       9.00         0.00       00500_REFTERA       0.00         0.00       00600_CAPTERA       0.00         0.00       00600_CAPTERA       0.00         0.00       00600_CAPTERA       SERVICE & SUPPLY         1.00       01100_CENTRAL SERVICE & SUPPLY       14.00         1.00       0100_CENTRAL SERVICE & SUPPLY       14.00         1.00       0100_CENTRAL SERVICE COST CENTERS       0         3.00       03000_ADULTESNIVE CASE COST CENTERS       0         3.00       03000_CARAL RECORDS & LIBERAY       0         MICHLARY SERVICE COST CENTERS       0         3.00       03000_CREATINE ROOM       0         0.0400_CRADUCTSNIVE CASE ONT       0         0.05000_LABORTONY       0       0         4.00       0.05000_LABORTONY       0         5.00       0500       0500       0.00         5.00       0500       0       0         5.00       0.00       0       0       0 </td <td>GENERAL S</td> <td>ERVICE COST CENTERS</td> <td>25.00</td> <td>20.00</td> <td></td> <td></td> <td></td> <td></td>	GENERAL S	ERVICE COST CENTERS	25.00	20.00				
4.00         00400 EMPLOVE ENERTITS DEPARTMENT         4.00           5.00         00500 ADMINISTRATION OF PLANT         5.00           6.00         00500 ADMINISTRATION OF PLANT         5.00           6.00         00500 ADMINISTRATION OF PLANT         5.00           6.00         00500 ADMINISTRATION OF PLANT         5.00           7.01         00         0100 CARETERIA         00.00           01.00         01000 CARETERIA         00.00         0100           11.00         01100 CARETERIA         STRATION         11.00           11.00         01100 CARETERIA         ENDANY         11.00           11.00         0100 CARETERIA         ENDANY         11.00           11.00         01000 CARETERIA         ENDANY         11.00           11.00         0100 CARETERIA         ENDANY         11.00           11.00         0100 CARETERIA         ENDANY         11.00           11.00								1.00
5.00         000000         ADM INI STRATI VE & GENERAL         5.00           7.00         00700 PERATI ON PELANT         8.00         00800 LAUNDRY & LINEN SERVICE         7.00           8.00         00800 LAUNDRY & LINEN SERVICE         9.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00	1 1							4.00
7. 00       000000       0PEANTION OF PLANT       7. 00         8. 00       000000       DUNREN SERVICE       9. 00         9. 00       000000       DETARY       10. 00         11. 00       01100 CAFETERIA       11. 00       01100 CAFETERIA       11. 00         13. 00       01300 CAFETERIA       11. 00       01400 CENTRAL SERVICE & SUPPLY       11. 00         15. 00       01400 CENTRAL SERVICE & SUPPLY       11. 00       11. 00       01400 CENTRAL SERVICE & SUPPLY       10. 00         16. 00       01400 CENTRAL SERVICE COST CENTERS       0       7. 00, 70. 022       30. 00       7. 00         30. 00       03000 ADULTS & PEDIATRICS       0       7. 00, 70. 022       31. 00       31. 00       31. 00       31. 00       31. 00       31. 00       31. 00       31. 00       31. 00       31. 00       31. 00       31. 00       31. 00       31. 00       31. 00       30. 00       31. 00       31. 00       31. 00       31. 00       31. 00       30. 00       31. 00       31. 00       30. 00       31. 00       30. 00       31. 00       30. 00       31. 00       30. 00       31. 00       30. 00       30. 00       31. 00       30. 00       31. 00       30. 00       30. 00       30. 00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>5.00</td></td<>								5.00
9.00         000900 HOUSEKEEPI NG         9.00           10.00         01000 CHETARY         10.00           11.00         01100 CAFETERIA         11.00           13.00         01300 CHETARY         11.00           13.00         01300 CHETARY         11.00           13.00         01400 CHETARAL SERVICE A SUPPLY         11.00           15.00         01500 HADRACY         11.00           16.00         01400 CHETARL SERVICE COST CENTERS         0           01000 ODEPHARINACY         0         76.02         31.00           10.00         03000 APULTS & PEDIATRICS         0         76.02         31.00           10.00         03000 APULTS & PEDIATRICS         0         77.02         54.00           54.00         05400 CPERATING ROM         0         229.178         54.00           54.00         05400 RADIOLGSY- BLAGNSTIC         0         170.189         54.00           54.00         06400 RADIOLGSY- DIAGNSTIC         0         170.189         54.00           54.00         05400 RADIOLGSY- BLAGNSTIC         0         170.189         54.00           54.00         05400 RADIOLGSY- DIAGNSTIC         0         170.189         54.00           50.00         06000 LABORA								7.00
10. 00         01000         D112RY         10. 00           11.00         0100         CARTERNA         11.00           11.00         0100         CARTERNA         00         11.00           11.00         0100         CARTERNA         00         11.00         11.00           11.00         0100         CARTERNA         00         11.00         11.00         11.00           11.00         01000         CARTERNA         0         11.00         11.02         11.02         11.02         11.02	8.00 00800 LAUN	NDRY & LINEN SERVICE						8.00
11.00       01100       CATETERIA       11.00         13.00       01300       NURSI NA ADMINI STRATION       11.00         14.00       014000       CENTRAL, SERVICE & SUPPLY       13.00         15.00       01500       HEDRAL, SERVICE & SUPPLY       14.00         16.00       01600       HEDRAL, SERVICE COST CENTERS       0         10.00       03000       ADDITS & PEDIATRICS       0       508, 792       30.00         30.00       03000       OPERATING CARE LINIT       0       76.022       31.00         ANCILLARY SERVICE COST CENTERS       0       170.189       54.00       54.00         54.00       054.00       000       0000       6250       62.00       62.00         65.00       06000       HAGMATTRY       0       76.799       65.00       65.00         66.00       064000       HYALERAPY       0       156.599       66.00       66.00         67.00       0000       0       0       0       0       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       69.00       73.00       73.00	9.00 00900 HOUS	SEKEEPI NG						9.00
13.00       01300 NURSI NG ADMINI STRATION       13.00         14.00       01400 CENTRAL SERVICE & SUPPLY       14.00         15.00       01500 PHARMACY       16.00         16.00       01500 MEDI CAL RECORDS & LIBRARY       16.00         10.00       01500 MEDI CAL RECORDS & LIBRARY       16.00         10.00       0100 NUTS SERVICE COST CENTERS       0         0.00       02100 INTERSIVE CARE UNIT       0       76.022         0.00       02000 PADIOTS A PEDIATRICS       0       76.022         0.00       02000 PADIOTS APEDIATRICS       0       76.722         0.00       02000 PADIOTS APEDIATRICS       0       76.729         50.00       05000 PADIOTARY POLACIDSTIC       0       17.232       54.00         50.00       06000 PESTICAL THERAPY       0       76.709       65.00         61.00       06000 PESTICAL THERAPY       0       76.709       65.00         61.00       06000 PESTICAL THERAPY       0       0       67.00       66.00         61.00       06000 PESTICAL THERAPY       0       0       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       68.00								10.00
14.0.0       01400       CENTRAL SERVICE & SUPPLY       14.00         15.00       01500       MEDICAL RECORDS & LIBRARY       16.00         10.00       00000       PADRAMCY       16.00         10.00       00000       ADDICAL RECORDS & LIBRARY       16.00         11.00       00000       PADRAMCY       0         0.0000       ADDICAL RECORDS & LIBRARY       0       508.792         0.0100       INTERS IVE CARE UNIT       0       76.022       31.00         0.0100       INTERS IVE CARE UNIT       0       76.022       31.00         0.0100       INTERS IVE CARE UNIT       0       17.232       54.00         0.0100       INACID CROPT DIAKNOSTI C       0       17.232       54.00         0.0100       INACID CROPT THERAPY       0       76.709       65.00         0.000       OCOU CRESPIR ATORY THERAPY       0       156.569       66.00       66.00         0.000       OCOU CRESPIR ATORIAL THERAPY       0       0       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>11.00</td>								11.00
15:00       OISGO PHARMACY       15:00       16:00       16:00         10:00       MPATI ENT ROUTINE SERVICE COST CENTERS       0       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       03:00       00:00       00:00								13.00
16.00       01600       MEDICAL RECORDS & LIBRARY       16.00         0.00       03000       ADULTS & PEDIATRICS       0       506, 792         30.00       03000       INTENSIVE CARE LUNIT       0       76, 022       30.00         ANCILLARY SERVICE COST CENTERS       0       76, 022       31.00         ANCILLARY SERVICE COST CENTERS       0       76, 022       54.00         50.00       054000       06400       0       172, 322       54.00         51.00       05000       0EX000       172, 322       54.00       56.00         62.00       062000       RESIP RATORY THERAPY       0       76, 709       66.00       66.00         65.00       066000       RESIP RATORY THERAPY       0       76, 709       66.00       66.00         66.00       066000       PKSIP RATORAL THERAPY       0       0       67, 709       66.00         71.00       0100 MEDICAL SUPPLIES CHARGED TO PATIENT       0       141.024       71.00       68.00         72.00       07300 RUBCAL SHARGED TO PATIENTS       0       73.00       76.00       76.00         73.00       07300 RUBCAL SHARGED TO PATIENTS       0       74.454       73.00       76.00								
INPAT ENT NOUTINE SERVICE COST CENTERS         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         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								
30.00         CASOOQ ADULTS & PEDIATRICS         0         508.792         30.00           31.00         CASOOQ ADULTS & PEDIATRICS         0         76.022         31.00           ANCILLARY SERVICE COST CENTERS         29,178         50.00         50.00         50.00         50.00         54.03         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         56.00         55.00         62.00         65.00         65.00         65.00         65.00         65.00         66.00         65.00         66.00         66.00         66.00         66.00         66.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00								16.00
31. 00       03100 INTENSIVE CARE UNIT       0       76,022       31. 00         ANCILLARY SERVICE COST CENTRS       0       229,178       50. 00         50. 00       05400 PADIOLOGY-DI AGNOSTIC       0       17,232       54. 00         64.01       05401 NUCLEAR MEDICINE-DI AGNOSTIC       0       17,232       54. 00         60.00       066000 LABORATORY       0       95,959       60. 00         60.00       066000 HYSICAL THERAPY       0       76,709       65. 00         60.00       06600 OPHYSICAL THERAPY       0       156,569       66. 00         60.00       0000 OPHYSICAL THERAPY       0       0       67. 00       68. 00         60.00       0000 OPHYSICAL THERAPY       0       0       0       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00       68. 00				F00 70				20.00
ANCLLIARY SERVICE COST CENTERS								
50.00         05000         0PERATING ROOM         0         229, 178         50.00           54.00         05400         NUCLEAR MEDICINE-DIAGNOSTIC         0         170, 189         54.00           64.00         05401         NUCLEAR MEDICINE-DIAGNOSTIC         0         177, 232         54.00           60.00         06000         MEDRATORY         NEARDATORY         0         95, 959         60.00           60.00         06000         BLODD & PACKED RED BLODD CELLS         0         265         62.00           60.00         06000         PHORORY         0         76, 709         65.00         66.00           60.00         06000         PHORORY         0         0         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         77.00         72.00         72.00 <td< td=""><td></td><td></td><td>U</td><td>76, 022</td><td>2</td><td></td><td></td><td>31.00</td></td<>			U	76, 022	2			31.00
54.00     054.00     RADIOLOCY-DIAGNOSTIC     0     170, 189     54.00       54.03     054.01     NUCLEAR MEDIOLRE-DIAGNOSTIC     0     17, 232     54.00       60.00     06000     LABORATORY     0     95, 959     60.00       62.00     06500     RESPI RATORY THERAPY     0     76, 709     65.00       66.00     06500     RESPI RATORY THERAPY     0     156, 569     66.00       67.00     06700     CCUPATIONAL THERAPY     0     156, 569     66.00       67.00     06700     CCUPATIONAL THERAPY     0     0     68.00       68.00     06800     SPECH PATHOLOGY     0     0     68.00       69.00     06900     LECETROCARDIOLOGY     0     0     68.00       71.00     07100     MEDICAL SUPPLIES CHARGE TO PATIENT     0     141, 024     71.00       72.00     73.00     7300     DRUGS CHARGE TO PATIENTS     0     78, 082     73.00       73.00     07300     PRUCE COST CENTERS     0     1, 727     90.00       00.01     09000     CLINIC     0     1, 727     90.00       90.02     09020     DESRIVATION     0     1, 727     90.00       90.03     099000     OMAREL MANGEMENT <td></td> <td></td> <td>0</td> <td>220 170</td> <td>2</td> <td></td> <td></td> <td>50.00</td>			0	220 170	2			50.00
54.03       05401       NUCLEAR MEDICINE-DIAGNOSTIC       0       17, 232       54.03         06.00       06000       LABORATORY       0       95, 959       60.00         06.00       06000       LABORATORY       0       76, 709       65.00         06.00       06000       PHSICAL THERAPY       0       156, 569       66.00         06.00       06000       SPECIAL PLATADRY THERAPY       0       0       0       66.00         06.00       06000       SPECIAL PLATADRY THERAPY       0       0       0       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       67.00       67.00       67.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       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								
60.00         06000         LABORATORY         0         95, 959         60.00           62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELLS         0         265         62.00           65.00         06500         RESPI RATORY THERAPY         0         76.709         66.00           66.00         06500         RESPI RATORY THERAPY         0         156,569         66.00           67.00         06700         OCCPATIONAL THERAPY         0         0         68.00           68.00         06800         SPECH PATHOLOGY         0         0         68.00         69.00           69.00         06900         LECTROCARDI OLOCY         0         0         74.2         72.00         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         74.2         72.00         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         73.00         73.00         73.00         73.00<			0					
62.00         06200         WHOLE BLODD & PACKED RED BLOOD CELLS         0         265         66.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         68.00         68.00         68.00         68.00         68.00         68.00         68.00         72.00         73.00         72.00         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         <			0					
65.00       06500       RESPIRATORY THERAPY       0       76,709       65.00         66.00       06600       PHYSICAL THERAPY       0       156,569       66.00         67.00       06200       DCCUPATIONAL THERAPY       0       0       67.00         68.00       06200       DCCUPATIONAL THERAPY       0       0       68.00       66.00         69.00       66000       ELECTROCARDIOLOGY       0       0       68.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       71.00       71.00       71.00       71.00       71.00       72.00       74.2       72.00       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       73.00       73.00       73.00       73.00       73.00       73.00	1 1		0					
66.00       06000       PHYSI CAL THERAPY       0       156, 569       66.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       72.00       72.00       72.00       72.00       72.00       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       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td>65.00</td>			0					65.00
68.00       06800       SPEECH PATHOLOGY       0       0       68.00         69.00       06900       ELECTROCARDIOLOGY       0       0       0         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       141,024       72.00         73.00       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       7300       73000       73000       73000       73000       730	1 1		0					66.00
69.00       06900       ELECTROCARDIOLOGY       0       0       0         71.00       07100       MEDICAL_SUPPLIES CHARGED TO PATIENT       0       141,024       71.00         72.00       7300       DRUGS CHARGED TO PATIENTS       0       742       73.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       742       73.00         70.00       0480       INFUSION THERAPY       0       44.454       76.00         0UTPATIENT SERVICE COST CENTERS       0       3,765       88.00       88.00       08801       RURAL HEALTH CLINIC       0       61,907       90.00       90.00       90.00       90.00       90.00       90.01       90.01       90.01       90.01       90.02       90.92 (OP PSYCH       0       12       90.01       90.02       90.02       90.92 (OP PSYCH       0       337,480       91.00       91.00       91.00       90.02       90.02 (OP DSYCH       0       337,480       91.00       91.00       91.00       91.00       91.00       92.00       92.00       92.00 (DSEKNATION BEDS (NON-DISTINCT PART       0       30,868       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00	1 1		0					67.00
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       141,024       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       742       73.00         73.00       DRUGS CHARGED TO PATIENTS       0       742       73.00         76.00       03480       INFUSION THERAPY       0       44,454       76.00         00       03800       RURAL HEALTH CLINIC       0       3,765       88.00       88.01         80.0       08300       RURAL HEALTH CLINIC       0       61,907       88.01       90.01         90.01       09000       CLINIC       0       1,727       90.01       90.02         90.02       09002       OP SYCH       0       0       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02       90.02 <t< td=""><td>68.00 06800 SPEF</td><td>ECH PATHOLOGY</td><td>0</td><td>(</td><td>o </td><td></td><td></td><td>68.00</td></t<>	68.00 06800 SPEF	ECH PATHOLOGY	0	(	o			68.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       742       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       78.082       73.00         76.00       03800       INFUSION THERAPY       0       44.454       76.00         0UTPATIENT SERVICE COST CENTERS       0       3.765       88.00       88.00       08801 RURAL HEALTH CLINIC       0       3.765       88.00         88.00       08801 RURAL HEALTH CLINIC II       0       61.907       90.01       90.00       90.00       1.727       90.00         90.01       09000       CLINIC       0       1.727       90.01       90.02         90.02       09020 (DP PSYCH       0       0       90.02       90.01       90.02       90.00       90.02       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00	69.00 06900 ELEC	CTROCARDI OLOGY	0	(	D			69.00
73.00       07300       DRUGS CHARGED TO PATIENTS       0       78.082       73.00         76.00       03480       INFUSION THERAPY       0       44.454       76.00         00       01701       SERVICE COST CENTERS       88.00       88.00       88.01       88.00       88.01       88.01       08800       RURAL HEALTH CLINIC       0       61.907       88.01       88.01       90.00       0000       CLINIC       0       1,727       90.01       90.00       90.02       09002       QPSYCH       0       12       90.01       90.02       90.02       09002       QP SYCH       0       0       337.480       90.02       92.00       052RVATION BEDS (NON-DISTINCT PART       0       337.480       91.00       92.00       09202 (DESERVATION BEDS (NON-DISTINCT PART       0       30.868       101.00       92.00       01000 HURERGENCY       0       30.868       101.00       92.00       92.00 (DSERVATION BEDS (NON-DISTINCT PART       0       30.868       101.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       114.00       0       50.519       144.00       0       144.00       04	71.00 07100 MEDI	ICAL SUPPLIES CHARGED TO PATIENT	0	141, 024	4			71.00
76.00         03480         INFUSION THERAPY         0         44,454         76.00           0UTPATI ENT SERVICE COST CENTERS         37.65         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         88.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00			-					72.00
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         0         3, 765         88.01           90.00         09000         CLINIC         0         61, 907         88.01           90.00         09000         CLINIC         0         1, 727         90.02           90.01         09001         DABETES         0         12         90.02           90.02         OP SYCH         0         0         90.02         90.02           90.03         PAIN MANAGEMENT         0         64, 395         90.03           91.00         OP100         EMERGENCY         0         337, 480         91.00           92.00         092000 (DSERVATI ON BEDS (NON-DI STINCT PART         0         30, 868         101.00           TOTHER RELIMBURSABLE COST CENTERS         101.00         10100 [HOME HEALTH AGENCY         0         30, 868         101.00           113.00         11300         INTERST EXPENSE         113.00         11300         118.00         11300         118.00         104.00         194.00         194.00         194.00         194.00         194.00         194.00         194.00         194.00         194.00         194.00         194.00         194.00<								73.00
88.00       08800       RURAL HEALTH CLINIC       0       3,765       88.00         88.01       08801       RURAL HEALTH CLINIC II       0       61,907       88.01         90.00       09000       CLINIC       0       1,727       90.01         90.01       09001       DI ABETES       0       1,727       90.01         90.02       09002       OP PSYCH       0       0       90.02         90.03       09003       PAIN MANAGEMENT       0       64,395       90.03         91.00       09100       EMERGENCY       0       337,480       91.00         92.00       092200       0BSERVATION       BEDS (NON-DI STINCT PART       0       30,868       101.00         011000       HORE HEALTH AGENCY       0       30,868       101.00       92.00       0         113.00       INTEREST EXPENSE       113.00       110100       1100E EXPENSE       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       114.01       0       104.02       0       104.01       0       104.01       0       104.01       0       104.01       0       104.02 </td <td></td> <td></td> <td>0</td> <td>44, 454</td> <td>4</td> <td></td> <td></td> <td>76.00</td>			0	44, 454	4			76.00
88.01       08001       RURAL HEALTH CLINICII       0       61,907       88.01         90.00       09000       CLINIC       0       1,727       90.00         90.01       09001       DI ABETES       0       12       90.00         90.02       09002       OP SYCH       0       0       90.02         90.03       09003       PAIN       MANAGEMENT       0       64,395       90.03         91.00       09100       EMERGENCY       0       337,480       91.00       92.00         92.00       092200       0BSERVATION       BEDS (NON-DISTINCT PART       0       30,868       101.00         10100       HOME HEALTH AGENCY       0       30,868       101.00       101.00       11300       11300       INTEREST EXPENSE       113.00       11300       11300       11300       11300       INTEREST EXPENSE       113.00       113.00       113.00       118.00       118.00       118.00       118.00       114.00       114.00       114.00       114.00       114.00       114.00       114.00       114.00       114.00       114.00       114.00       114.00       114.00       114.00       114.00       114.00       114.00       114.00       114.00 <td></td> <td></td> <td></td> <td>0.7/</td> <td>-1</td> <td></td> <td></td> <td>00.00</td>				0.7/	-1			00.00
90.00       09000       CLINIC       0       1,727       90.00         90.01       09001       DIABETES       0       12       90.01         90.02       09002       QP PSYCH       0       0       90.03         90.03       09003       PAIN       MAAGEMENT       0       64,395       90.03         91.00       09100       EMERGENCY       0       337,480       91.00         92.00       OBSERVATION       BEDS (NON-DISTINCT PART       0       30,868       91.00         01.00       HOME       HEALTH AGENCY       0       30,868       101.00         01.00       HOME       HEALTH AGENCY       0       30,868       101.00         113.00       INTEREST EXPENSE       113.00       SUBTOTALS (SUM OF LINES 1 through 117)       0       2,095,371       118.00         114.00       SUBTOTALS (SUM OF LINES 1 through 117)       0       303,936       194.00       194.00         194.01       07951       FOUNDATION       0       303,936       194.00       194.00       194.00       194.00         194.02       07952       ASC       0       0       0       194.00       194.00       194.00       194.00       194.								
90.01       09001       DI ABETES       0       12       90.01         90.02       09002       OP PSYCH       0       0       0         90.03       09003       PAI N MANAGEMENT       0       64, 395       90.03         91.00       09100       EMERGENCY       0       337, 480       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0       303, 868       90.01         01.00       10100       HOME HEALTH AGENCY       0       30, 868       101.00       92.00         91.300       INTEREST EXPENSE       113.00       INTEREST EXPENSE       113.00       113.00       11800 INTEREST CENTERS       113.00       118.00       118.00       118.00       118.00       118.00       118.00       118.00       118.00       118.00       1194.01       07950       MOB       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02       194.02			0					
90. 02       09002       0P PSYCH       0       0       90. 02         90. 03       09003       PAI N MANAGEMENT       0       64, 395       90. 03         91. 00       09100       EMERGENCY       0       337, 480       91. 00         92. 00       09SERVATI ON BEDS (NON-DI STI NCT PART       0       337, 480       92. 00         0100       HOME HEALTH AGENCY       0       30, 868       101. 00         010100       HOME HEALTH AGENCY       0       30, 868       101. 00         113.00       INTEREST EXPENSE       113. 00       11300       INTEREST EXPENSE       113. 00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       0       2, 095, 371       118. 00         194. 00       07950       MOB       0       303, 936       194. 00         194. 01       07951       FOUNDATI ON       0       50, 519       194. 00         194. 02       07952       ASC       0       0       194. 00         194. 03       07953       SNF - PERRY CO.       0       0       194. 00         194. 04       07954       TELE BEHAVI ORAL       0       0       194. 00         194. 04       07953       SNF - PERRY CO.<			0					
90.03       09003       PAI N MANAGEMENT       0       64,395       90.03         91.00       09100       EMERGENCY       0       337,480       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0       337,480       92.00         0HER       REIMBURSABLE COST CENTERS       0       30,868       101.00         101.00       HOME HEALTH AGENCY       0       30,868       101.00         SPECIAL PURPOSE COST CENTERS       113.00       113.00       INTEREST EXPENSE       113.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       0       2,095,371       118.00         194.00       07950       MOB       0       303,936       194.00         194.01       07951       FOUNDATI ON       0       50,519       194.00         194.02       07952       ASC       0       0       194.00         194.03       07953       SNF - PERRY CO.       0       0       194.00         194.04       07954       TELE BEHAVI ORAL       0       0       194.00         194.02       07952       ASC       0       0       194.00         194.03       07953       SNF - PERRY CO.       0 </td <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0					
91.00       09100       EMERGENCY       0       337,480       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0       92.00         0THER       REIMBURSABLE COST CENTERS       92.00         101.00       10100       HOME HEALTH AGENCY       0       30,868       101.00         SPECIAL PURPOSE COST CENTERS       101.00       101.00       101.00       101.00       113.00       1NTEREST EXPENSE       113.00         113.00       INTEREST EXPENSE       0       2,095,371       118.00         104.00       07950       MOB       0       303,936       194.00         194.01       07951       FOUNDATION       0       50,519       194.00         194.02       07952       ASC       0       0       194.00         194.03       07953       SNF - PERRY CO.       0       0       194.00         194.04       07954       TELE BEHAVIORAL       0       0       194.00         194.04       07954       SNF - PERRY CO.       0       0       194.00         194.04       07954       TELE BEHAVIORAL       0       0       194.00         194.04       07954       STELE BEHAVIORAL			0		-			
92.00       09200       0BSERVATION BEDS (NON-DISTINCT PART       0       92.00         0THER       REIMBURSABLE COST CENTERS       101.00       10100       HOME HEALTH AGENCY       0       30,868       101.00         101.00       10100       HOME HEALTH AGENCY       0       30,868       101.00         SPECIAL PURPOSE COST CENTERS         113.00       INTERST EXPENSE       113.00       11000       11000       11000       11000       11000       113.00       118.00         NONREI MBURSABLE COST CENTERS         114.00       07950       MOB       0       303,936       194.00         194.00       07950       MOB       0       50,519       194.00         194.02       07952       ASC       0       0       194.02         194.03       07953       SNF - PERRY CO.       0       0       194.03         194.03       07953       SNF - PERRY CO.       0       0       194.03         194.03       07954       TELE BEHAVI ORAL       0       0       194.03         200.00       Cross Foot Adjustments       0       0       0       200.00			Ű					
OTHER         REI MBURSABLE         COST         CENTERS           101.00         HOME         HEALTH         AGENCY         0         30, 868         101.00           SPECI AL         PURPOSE         COST         CENTERS         113.00         INTEREST         EXPENSE         113.00           118.00         SUBTOTALS         (SUM OF LINES 1 through 117)         0         2,095,371         118.00           NONREI         MBURSABLE         COST         CENTERS         114.00         194.00           194.00         07950         MOB         0         303,936         194.00           194.01         07951         FOUNDATION         0         50,519         194.00           194.02         07952         ASC         0         0         194.02           194.03         07953         SNF         PERRY         CO.         194.02           194.04         07954         TELE         BEHAVI ORAL         0         0         194.04           200.00         Cross Foot Adjustments         0         0         0         200.00			-	007, 100				
101.00       HOME HEALTH AGENCY       0       30,868       101.00         SPECIAL PURPOSE COST CENTERS         113.00       INTEREST EXPENSE       113.00         SUBTOTALS (SUM OF LINES 1 through 117)       0       2,095,371       118.00         NONREI MBURSABLE COST CENTERS         194.00       07950       MOB       0       303,936       194.00         194.01       07951       FOUNDATION       0       50,519       194.00         194.02       07952       ASC       0       0       194.02       194.02       194.02         194.03       07953       SNF - PERRY CO.       0       0       194.02       194.04       04       04       0       0       0       194.04       04       0       0       0       0       194.04       04       0       0       0       0       194.04       04       0       0       0       0       194.04       04       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			-1		1			
SPECIAL PURPOSE COST CENTERS           113.00         INTEREST EXPENSE           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         0         2,095,371           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         0         2,095,371           194.00         07950         MOB         0         303,936           194.01         07951         FOUNDATI ON         0         50,519           194.02         07952         ASC         0         0           194.03         07953         SNF - PERRY CO.         0         0           194.04         07954         TELE BEHAVI ORAL         0         0           200.00         Cross Foot Adj ustments         0         0         0			0	30, 868	3			101.00
118.00         SUBTOTALS (SUM OF LINES 1 through 117)         0         2,095,371         118.00           NONREL MBURSABLE COST CENTERS           194.00         07950         MOB         0         303,936         194.00           194.01         07951         FOUNDATI ON         0         50,519         194.01           194.02         07952         ASC         0         0         194.02           194.03         07953         SNF - PERRY CO.         0         0         194.02           194.04         07954         TELE BEHAVI ORAL         0         0         194.04           200.00         Cross Foot Adjustments         0         0         0         200.00					-			
NONREI MBURSABLE COST CENTERS         194.00         303,936         194.00           194.00         07950         MOB         0         303,936         194.00           194.01         07951         FOUNDATI ON         0         50,519         194.00           194.02         07952         ASC         0         0         194.02           194.03         07953         SNF - PERRY CO.         0         0         194.03           194.04         07954         TELE         BEHAVI ORAL         0         0         194.04           200.00         Cross Foot Adj ustments         0         0         0         200.00								113.00
NONREI MBURSABLE COST CENTERS         194.00         303,936         194.00           194.00         07950         MOB         0         303,936         194.00           194.01         07951         FOUNDATI ON         0         50,519         194.00           194.02         07952         ASC         0         0         194.02           194.03         07953         SNF - PERRY CO.         0         0         194.03           194.04         07954         TELE         BEHAVI ORAL         0         0         194.04           200.00         Cross Foot Adj ustments         0         0         0         200.00	118.00 SUB7	TOTALS (SUM OF LINES 1 through 117)	0	2,095,371	1			118.00
194.01       07951       FOUNDATION       0       50, 519       194.01         194.02       07952       ASC       0       0       194.02         194.03       07953       SNF - PERRY CO.       0       0       194.03         194.04       07954       TELE BEHAVI ORAL       0       0       194.04         200.00       Cross Foot Adjustments       0       0       200.00	NONREI MBUR	RSABLE COST CENTERS						
194.02       07952       ASC       0       0       194.02         194.03       07953       SNF - PERRY CO.       0       0       194.03         194.04       07954       TELE BEHAVI ORAL       0       0       194.04         200.00       Cross Foot Adjustments       0       0       200.00			0	303, 936	5			194.00
194.03       07953       SNF - PERRY CO.       0       0       194.03         194.04       07954       TELE BEHAVI ORAL       0       0       194.04         200.00       Cross Foot Adjustments       0       0       200.00       0			0	50, 519	9			194.01
194.04         07954         TELE         BEHAVI ORAL         0         0         194.04           200.00         Cross Foot Adjustments         0         0         0         200.00			0	(	0			194.02
200.00 Cross Foot Adjustments 0 0 0 200.00			0	(	0			194.03
	1 1		0	(	D			194.04
			0	(				
					-			201.00
202.00       TOTAL (sum lines 118 through 201)       0       2,449,826       202.00	202.00  1014	AL (SUM LINES II8 through 201)	0	2, 449, 826				202.00

		ncial Systems TION - STATISTICAL BASIS	DEACONESS		CN: 15-1319 P	In Lie eriod:	u of Form CMS-2 Worksheet B-1	
CUSTA	LLUCA	TION - STATISTICAL DASIS		FIOVIDELC	F	rom 10/01/2020		
						09/30/2021	Date/Time Pre 2/28/2022 10:	
			CAPI TAL					
			RELATED COSTS					
		Cost Center Description	BLDG & FIXT	EMPLOYEE		ADMI NI STRATI V	OPERATION OF	
			(SQUARE FEET)	BENEFITS	n	E & GENERAL	PLANT	
				DEPARTMENT (GROSS		(ACCUM. COST)	(SQUARE FEET)	
				SALARI ES)				
			1.00	4.00	5A	5.00	7.00	
	GENER	AL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	91, 808					1.00
4.00		EMPLOYEE BENEFITS DEPARTMENT	792	12, 746, 104				4.00
5.00		ADMINI STRATI VE & GENERAL	4, 994	1, 530, 210				5.00
7.00		OPERATION OF PLANT	25, 048	208, 130		_, ,		
8.00 9.00		LAUNDRY & LI NEN SERVI CE HOUSEKEEPI NG	1, 630 920	66, 313	0			
	1	DIETARY	1, 130	284, 260 89, 223	-		920	•
	1	CAFETERIA	3, 055	239, 145				
		NURSI NG ADMI NI STRATI ON	276	94, 813			276	
		CENTRAL SERVICE & SUPPLY	0	140, 697	0			
15.00	01500	PHARMACY	1, 342	224, 218	0	3, 755, 406	1, 342	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1, 333	106, 442	0	290, 439	1, 333	16.00
		IENT ROUTINE SERVICE COST CENTERS	,		1			
		ADULTS & PEDIATRICS	9, 164	1, 981, 772				
31.00			1, 936	16, 161	0	79, 299	1, 936	31.00
F0 00		LARY SERVICE COST CENTERS	E 104	1 101 704		1 040 200	E 104	50.00
50.00 54.00		OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	5, 104 3, 496	1, 181, 704 972, 095				1
54.00 54.03		NUCLEAR MEDICINE-DIAGNOSTIC	420	972,093	0			
		LABORATORY	1, 530	761, 938				•
62.00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	Ő	-, -==,		
65.00		RESPI RATORY THERAPY	1, 612	504, 620	0		1, 612	
66.00	06600	PHYSI CAL THERAPY	3, 690	23, 845		2, 108, 695	3, 690	66.00
67.00	06700	OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
		SPEECH PATHOLOGY	0	0	0		0	
		ELECTROCARDI OLOGY	0	0	0	-	0	
		MEDICAL SUPPLIES CHARGED TO PATIENT	3, 589	0	0			•
		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0	0		0	
		INFUSION THERAPY	1,067	121, 200			1,067	•
70.00		TIENT SERVICE COST CENTERS	1,007	121,200		241,477	1,007	/0.00
88.00		RURAL HEALTH CLINIC	0	328, 428	0	783, 168	0	88.00
	08801	RURAL HEALTH CLINIC II	1, 440	735, 378		1, 275, 975	1, 440	•
90.00	09000	CLINIC	0	59, 443	0	104, 307	0	90.00
		DIABETES	0	0	0	1, 450	0	
		OP PSYCH	0	0	0		0	
		PAIN MANAGEMENT	1, 575	125, 685				
		EMERGENCY	7, 782	1, 148, 513	0	3, 275, 431	7, 782	
		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS					<u>i</u>	92.00
		HOME HEALTH AGENCY	505	453, 033	0	955, 342	505	101.00
		AL PURPOSE COST CENTERS	505	100,000		,55, 542		1
113.00		INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83, 430	11, 397, 266	-7, 383, 824	30, 094, 813		118.00
		IMBURSABLE COST CENTERS						
194.00			7,069	1, 348, 657	0	2, 942, 770		194.00
		FOUNDATION	1, 309	181	0			194.01
194.02	1		0	0	0			194.02
		SNF - PERRY CO.	0	0	0			194.03
		TELE BEHAVI ORAL	0	0	0	0		194.04
200.00		Cross Foot Adjustments Negative Cost Centers						200.00 201.00
201.00		Cost to be allocated (per Wkst. B,	2, 449, 826	3, 915, 556		7, 383, 824		•
202.00		Part I)	2, 447, 020	5, 715, 550		7, 303, 024	3, 337, 311	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26. 684232	0. 307196		0. 223287	58.016712	203.00
204.00		Cost to be allocated (per Wkst. B,		21, 134		135, 798		
		Part II)						
205.00	)	Unit cost multiplier (Wkst. B, Part		0. 001658		0. 004107	11. 162282	205.00
		11)					1	
206.00		NAHE adjustment amount to be allocated					1	206.00
207.00		(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.00
207.00	1	Parts III and IV)					1	207.00
	1		1 I		1	I	1	1

	Financial Systems	DEACONESS				u of Form CMS-2	
COST AL	LOCATION - STATISTICAL BASIS		Provider CC		Period: From 10/01/2020	Worksheet B-1	
					Го 09/30/2021	Date/Time Pre 2/28/2022 10:	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
			(SQUARE FEET)	(PATI ENT	(GROSS	ADMI NI STRATI O	
		(PATI ENT DAYS)		DAYS)	SALARI ES)	N (NURSE	
		DATS)				SALARI ES)	
		8.00	9.00	10.00	11.00	13.00	
	GENERAL SERVICE COST CENTERS	1	1 1		1		
1	DO100 CAP REL COSTS-BLDG & FLXT DO400 EMPLOYEE BENEFLTS DEPARTMENT						1.00
	DOGOO ADMINISTRATIVE & GENERAL						4.00
	DO700 OPERATION OF PLANT						7.00
	DO800 LAUNDRY & LINEN SERVICE	2, 461					8.00
	DO900 HOUSEKEEPI NG	0	58, 424				9.00
	D1000 DI ETARY	0	1, 130	2, 46			10.00
	D1100 CAFETERIA D1300 NURSING ADMINISTRATION	0	3, 055 276	(	.,,	6, 783, 086	11.00
	D1400 CENTRAL SERVICE & SUPPLY	0	2/0	(		0, 703, 000	14.00
	D1500 PHARMACY	0	1, 342	(		204, 112	
	D1600 MEDICAL RECORDS & LIBRARY	0	1, 333	(	106, 442	0	16.00
	NPATIENT ROUTINE SERVICE COST CENTERS		0.4(4			1 05 1 (70	
	D3000 ADULTS & PEDIATRICS	2, 440		2,440		1, 954, 678	
	D3100 INTENSIVE CARE UNIT ANCILLARY SERVICE COST CENTERS	21	1, 936	2	1 16, 161	0	31.00
	D5000 OPERATING ROOM	0	5, 104	(	1, 181, 704	712, 192	50.00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	0	3, 496	(		905, 779	54.00
1	D5401 NUCLEAR MEDICINE-DIAGNOSTIC	0	420	(		0	
		0	1, 530	(	761, 938	709, 945	
	D6200 WHOLE BLOOD & PACKED RED BLOOD CELLS D6500 RESPI RATORY THERAPY	0	0 1, 612		504,620	0 455, 337	62.00 65.00
	D6600 PHYSI CAL THERAPY	0	3, 690	(		455, 557	66.00
	D6700 OCCUPATI ONAL THERAPY	0	0,0,0	(	0 0	0	
	D6800 SPEECH PATHOLOGY	0	0	(	0 0	0	68.00
	D6900 ELECTROCARDI OLOGY	0	0	(	0 0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	3, 589	(	0	0	
	D7200 I MPL. DEV. CHARGED TO PATIENTS D7300 DRUGS CHARGED TO PATIENTS		0	(		0	72.00
	03480 I NFUSI ON THERAPY	0	1,067	(		115, 728	
(	DUTPATIENT SERVICE COST CENTERS						
	D8800 RURAL HEALTH CLINIC	0		(		0	
	D8801 RURAL HEALTH CLINIC II D9000 CLINIC	0	1, 440	(		0 57, 092	
	D9000 CLINIC D9001 DI ABETES	0	0	(	0 59,443	57,092	90.00
	09002 OP PSYCH	0	0	(	0	0	1
90.03	D9003 PALN MANAGEMENT	0	1, 575	(	125, 685	121, 961	90.03
	D9100 EMERGENCY	0	7, 782	(	1, 148, 513	1, 098, 057	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	DTHER REIMBURSABLE COST CENTERS	0	505	(	453, 033	448, 205	101 00
	SPECIAL PURPOSE COST CENTERS	0	505		435,035	440, 205	
	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	2, 461	50, 046	2, 46	1 7, 916, 179	6, 783, 086	118.00
	NONREI MBURSABLE COST CENTERS		7.0(0		4 949 (57	0	101.00
	07950 MOB 07951 FOUNDATI ON	0	7, 069 1, 309	(			194.00 194.01
	07952 ASC	0	1, 307	(			194.01
	D7953 SNF - PERRY CO.	0	0	(	0 0		194.03
	07954 TELE BEHAVI ORAL	0	0	(	0 0	0	194.04
200.00	Cross Foot Adjustments						200.00
201.00 202.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	287, 810	819, 225	414, 898	3 777, 591	312, 904	201.00
202.00	Part I)	207,010	019, 220	414, 698	5 111, 371	512, 904	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	116. 948395	14. 022063	168. 589191	0. 083928	0. 046130	203.00
204.00	Cost to be allocated (per Wkst. B,	62, 449		44, 766		12, 966	
	Part II)						
	Unit cost multiplier (Wkst. B, Part	25. 375457	0. 648021	18. 190167	0. 012938	0. 001912	205.00
205.00		1	1				1
	II) NAHE adjustment amount to be allocated						206 00
205.00 206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
	NAHE adjustment amount to be allocated						206. 00 207. 00

Heal th	Financial Systems	DEACONESS	GI BSON		In Lieu of Form CMS	8-2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider CO	CN: 15-1319	Period: Worksheet B From 10/01/2020	-1
					To 09/30/2021 Date/Time P 2/28/2022 1	
	Cost Center Description	CENTRAL SERVI CE & SUPPLY (COSTED REQUI S.) 14.00	PHARMACY (COSTED REQUI S. ) 15. 00	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00		
	GENERAL SERVICE COST CENTERS					
11.00 13.00 14.00 15.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CE & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY INPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 641, 922 10, 314 30	100 0		79	$\begin{array}{c} 1.00\\ 4.00\\ 5.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ \end{array}$
	03000 ADULTS & PEDI ATRI CS	77, 349	0	5, 071, 20	06	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	26, 68	39	31.00
54.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	231, 896 51, 692 786	0	17, 200, 18	30	50.00 54.00 54.03
60.00	06000 LABORATORY	520, 482	0	14, 268, 80	02	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPI RATORY THERAPY	137 19, 428	0	137, 31 4, 189, 22		62.00 65.00
66.00	06600 PHYSI CAL THERAPY	14, 923	0	7, 884, 21		66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0	67.00 68.00
	06900 ELECTROCARDI OLOGY	0	0		0	69.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	413, 196	0		0	71.00
	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	123, 981 0	0 100		0	72.00
	03480 I NFUSI ON THERAPY	20, 304	0			76.00
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	2,054	0		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	8, 637	0		0	88.01
	09000 CLI NI C 09001 DI ABETES	17, 865 0	0	413, 29 9, 12		90.00 90.01
	09002 OP PSYCH	0	0		0	90.01
	09003 PAIN MANAGEMENT	2, 726	0			90.03
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	82, 497	0	7, 825, 33	34	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS				- 1	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	18, 656	0		0	101.00
	11300 I NTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 616, 953	100	77, 711, 57	79	118.00
	07950 MOB	24, 969	0		0	194.00
	07951 FOUNDATI ON 07952 ASC	0	0		0	194.01 194.02
	07953 SNF - PERRY CO.	0	0		0	194.02
	07954 TELE BEHAVI ORAL	0	0		0	194.04
200.00 201.00	5					200.00 201.00
202.00	Cost to be allocated (per Wkst. B,	320, 376	4, 720, 876	460, 25	56	202.00
203.00 204.00	Cost to be allocated (per Wkst. B,	0. 195123 3, 089	47, 208. 760000 70, 750			203. 00 204. 00
205.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 001881	707. 500000	0. 00069	96	205.00
206.00	II) NAHE adjustment amount to be allocated					206.00
	(per Wkst. B-2)					
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

Health Financial Systems	DEACONESS	GIBSON		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			CN: 15-1319	Period: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Pre 2/28/2022 10:	epared: 06 am
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	1			
30. 00 03000 ADULTS & PEDIATRICS	5, 646, 753		5, 646, 75		0	
31.00 03100 INTENSIVE CARE UNIT	243, 982		243, 98	32 0	0	31.00
ANCILLARY SERVICE COST CENTERS	1	1	1			
50.00 05000 OPERATING ROOM	2, 848, 194		2, 848, 19		0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 766, 485		2, 766, 48		0	
54.03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	221, 938		221, 93		0	
60. 00 06000 LABORATORY	4, 465, 242		4, 465, 24		0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	51, 102		51, 10		0	
65. 00 06500 RESPI RATORY THERAPY	1, 240, 282	0	.,		0	
66.00 06600 PHYSI CAL THERAPY	2, 896, 973	0	2, 896, 9	73 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	961, 782		961, 78		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	175, 856		175, 85		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 783, 271		4, 783, 2		0	
76.00 03480 INFUSION THERAPY	394, 804		394, 80	04 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	958, 440		958, 44		0	
88.01 08801 RURAL HEALTH CLINIC II	1, 666, 305		1, 666, 30		0	
90. 00 09000 CLINIC	141, 154		141, 15		0	
90. 01 09001 DI ABETES	1, 828		1, 82		0	
90. 02 09002 OP PSYCH	0			0 0	0	
90. 03 09003 PAIN MANAGEMENT	584, 335		584, 33		0	
91.00 09100 EMERGENCY	4, 776, 889		4, 776, 88		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 814, 662		1, 814, 60	52	0	92.00
OTHER REIMBURSABLE COST CENTERS	1	1	1			
101.00 10100 HOME HEALTH AGENCY	1, 267, 374		1, 267, 3	74	0	101.00
SPECIAL PURPOSE COST CENTERS			1	1		
113. 00 11300 INTEREST EXPENSE		_			-	113.00
200.00 Subtotal (see instructions)	37, 907, 651					200.00
201.00 Less Observation Beds	1, 814, 662		1, 814, 60			201.00
202.00  Total (see instructions)	36, 092, 989	0	36, 092, 98	39 0	0	202.00

Health Financia	I Systems	DEACONESS	GI BSON		In Lie	u of Form CMS-	2552-10
COMPUTATION OF	RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
					From 10/01/2020 To 09/30/2021	Part I Date/Time Pre	nared
					10 097 307 2021	2/28/2022 10:	06 am
			Title	× XVIII	Hospi tal	Cost	
			Charges				
Cos	st Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Rati o	I npati ent	
						Rati o	
		6.00	7.00	8.00	9.00	10.00	
	T ROUTINE SERVICE COST CENTERS	T					
	JLTS & PEDIATRICS	2, 290, 675		2, 290, 67			30.00
	TENSI VE CARE UNI T	26, 689		26, 68	9		31.00
	Y SERVICE COST CENTERS						
	ERATING ROOM	85, 635	7,052,097				
	DI OLOGY-DI AGNOSTI C	427, 430	15, 822, 095				
	CLEAR MEDICINE-DIAGNOSTIC	7, 920	614, 388			0.00000	
60.00 06000 LAE		795, 890	13, 472, 912			0.00000	
	DLE BLOOD & PACKED RED BLOOD CELLS	52, 386	151, 524			0.00000	
	SPI RATORY THERAPY	390, 842	3, 291, 585			0.00000	
	SI CAL THERAPY	1, 497, 878	7, 775, 928	9, 273, 80		0.00000	
	CUPATIONAL THERAPY	0	0		0 0. 000000	0.00000	
	EECH PATHOLOGY	0	0		0 0. 000000	0. 000000	
	ECTROCARDI OLOGY	0	0		0 0. 000000	0. 000000	
	DICAL SUPPLIES CHARGED TO PATIENT	334, 221	554, 106			0. 000000	
	PL. DEV. CHARGED TO PATIENTS	2, 412	431, 520			0. 000000	
	JGS CHARGED TO PATIENTS	1, 683, 642	9, 829, 405			0.00000	
76.00 03480 I NF		10, 173	641, 498	651, 67	1 0. 605833	0. 000000	76.00
	NT SERVICE COST CENTERS	-			-		
	RAL HEALTH CLINIC	0	744, 946				88.00
	RAL HEALTH CLINIC II	0	1, 777, 128				88.01
90.00 09000 CLI		0	413, 742				
90.01 09001 DI A		0	9, 122				
90.02 09002 0P		0	0		0 0.000000	0.00000	
	N MANAGEMENT	0	247, 889			0.00000	
91.00 09100 EME		253, 689	7, 309, 339			0.00000	
	SERVATION BEDS (NON-DISTINCT PART	61, 182	1, 058, 371	1, 119, 55	3 1. 620881	0.00000	92.00
	I MBURSABLE COST CENTERS		000 070	000.07			101 00
	ME HEALTH AGENCY	0	920, 372	920, 37	2		101.00
	PURPOSE COST CENTERS			1			112 00
113.00 11300 I NT		7 000 ///	70 117 0/7	00.000 (0	1		113.00
	ototal (see instructions)	7, 920, 664	72, 117, 967	80, 038, 63			200.00 201.00
	ss Observation Beds	7 020 ///	70 117 0/7	00.000 (0	1		
202.00  Tot	tal (see instructions)	7, 920, 664	72, 117, 967	80, 038, 63	4		202.00

Health Financial Systems	DEACONESS G	GI BSON	In Lieu	」of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1319	Period: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Pr 2/28/2022 10	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000				54.03
60. 00 06000 LABORATORY	0. 000000				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000				67.00
68.00 06800 SPEECH PATHOLOGY	0.000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76. 00 03480 I NFUSI ON THERAPY	0. 000000				76.00
OUTPATIENT SERVICE COST CENTERS	0.000000				10100
88.00 08800 RURAL HEALTH CLINIC					88.00
88. 01 08801 RURAL HEALTH CLINIC II					88.01
90. 00 09000 CLINIC	0.000000				90.00
90. 01 09001 DI ABETES	0. 000000				90.01
90. 02 09002 0P PSYCH	0. 000000				90.02
90. 03 09003 PALN MANAGEMENT	0. 000000				90.03
91. 00 09100 EMERGENCY	0. 000000				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS	0.000000				72.00
101.0010100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS	I				
113. 00 11300 I NTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					200.00
202.00 Total (see instructions)					201.00
	I I				1202.00

Health Financial Systems	DEACONESS	GI BSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1319	Period: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Pre 2/28/2022 10:	pared: 06 am
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	5, 646, 753		5, 646, 75		5, 646, 753	
31.00 03100 INTENSIVE CARE UNIT	243, 982		243, 98	32 0	243, 982	31.00
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATING ROOM	2, 848, 194		2, 848, 19		2, 848, 194	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 766, 485		2, 766, 48		2, 766, 485	
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	221, 938		221, 93		221, 938	
60. 00 06000 LABORATORY	4, 465, 242		4, 465, 24		4, 465, 242	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	51, 102		51, 10		51, 102	
65. 00 06500 RESPI RATORY THERAPY	1, 240, 282	0	.,		1, 240, 282	65.00
66.00 06600 PHYSI CAL THERAPY	2, 896, 973	0	2, 896, 97	0	2, 896, 973	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	68.00 69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	961, 782		961, 78		961, 782	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	175, 856		175, 85		175, 856	
73. 00 07300 DRUGS CHARGED TO PATIENTS	4, 783, 271		4, 783, 27		4, 783, 271	
76.00 03480 INFUSION THERAPY	394, 804		4, 783, 21		394, 804	76.00
OUTPATIENT SERVICE COST CENTERS	374,004		374, 00	0	374,004	70.00
88.00 08800 RURAL HEALTH CLINIC	958, 440		958, 44	0 0	958, 440	88.00
88.01 08801 RURAL HEALTH CLINIC II	1, 666, 305		1, 666, 30		1, 666, 305	
90. 00 09000 CLINIC	141, 154		141, 15		141, 154	
90. 01 09001 DI ABETES	1, 828		1, 82		1, 828	90.01
90. 02 09002 OP PSYCH	0		.,	0 0	0	90.02
90. 03 09003 PALN MANAGEMENT	584, 335		584, 33	35 0	584, 335	90.03
91. 00 09100 EMERGENCY	4, 776, 889		4, 776, 88		4, 776, 889	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 814, 662		1, 814, 66		1, 814, 662	92.00
OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					1
101.00 10100 HOME HEALTH AGENCY	1, 267, 374		1, 267, 37	4	1, 267, 374	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	37, 907, 651	0	37, 907, 65	51 0		
201.00 Less Observation Beds	1, 814, 662		1, 814, 66		1, 814, 662	
202.00   Total (see instructions)	36, 092, 989	0	36, 092, 98	39 0	36, 092, 989	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES         Provider CCN: 15-1319         Period: From 10/01/2020 To 09/30/2021         Worksheet C 206 am         Worksheet C 2022 10:06 am           Title XIX           Worksheet C marked by the properties to 00000 ADULTS & PEDIATRICS         Title XIX         Hospital         Cost         Cost<	Health Financial Systems	DEACONESS	GI BSON		In Lie	u of Form CMS-:	2552-10
Impatient         Total         09/30/2021         Date/Time Prepared: 22/22/222 10:06 am           Cost Center Description         Inpatient         Outpatient         Total (col. 7)         Cost or Other Ratio         TEFRA Inpatient           000         03000 ADULTS & PEDIATRICS         2.290,675         2.290,675         30.00           010         03000 ADULTS & PEDIATRICS         2.6,69         2.6,69         31.00           0         03000 ADULTS & PEDIATRICS         2.290,675         2.290,675         30.00           0.00         03000 ADULTS & PEDIATRICS         2.6,69         30.00         31.00           0.01 INTENSIVE CARE UNIT         26,69         2.6,69         30.000         30.00           40.00 GEODO PERSTING ROOM         85,635         7.052,097         7.137,732         0.399033         0.0000000           50.00 GEODO PERSTING ROOM         85,635         7.052,097         7.137,732         0.399033         0.0000000         60.00           60.00 GEODO HADIALGORY PIERAPY         792         161.438         624.27,308         0.312937         0.0000000         60.00           60.00 GESPIRATORY HERAPY         1497.878         7.75.928         9.273,866         0.312937         0.000000         65.00         65.00         65.00         65.0	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1319			
Image: construction         Title XIX         Hospital         Cost         Cost <thcost< th="">         Cost         <thcost< th=""> <th< td=""><td></td><td></td><td></td><td></td><td></td><td>Part I</td><td></td></th<></thcost<></thcost<>						Part I	
Impatient         Impatient         Impatient         Cost Center Description           Impatient         Outpatient         Total (col. 6 + col. 7)         Cost other Ratio         Cost Center Description           30.00         03000 ADULTS & PEDIATRICS         2.290, 675         2.290, 675         2.290, 675         30.00         30.00           30.00         03000 ADULTS & PEDIATRICS         2.6, 689         2.290, 675         2.6, 699         30.00         31.00           ANCI LLARY SERVICE COST CENTERS         30.00         51.00         55.000         0.000000 PERATINE ROM         85, 635         7.052, 097         7.137, 732         0.399033         0.0000000         54.00           54.00         05400 (RADI LOCARY EROM         7.920         614, 388         622, 305         0.3100         0.000000         54.00           65.00         06500 (MHOLE BLODD & PACKED RED BLODD CELLS         52, 386         151, 524         23, 642         0.336811         0.000000         65.00           65.00         06500 (PHYSI CAL THERAPY         1, 497, 878         7.75, 928         9.273.806         0.312937         0.000000         65.00           66.00         06600 (PHYSI CAL THERAPY         1, 497, 878         7.7					10 09/30/2021	2/28/2022 10	of am
Cost Center Description         Charges - transmission         Cost Conternation         TEFRA atio           1 npatient         0utpatient         Total (col. f. + col. 7)         Cost or Other Ratio         Inpatient Ratio           30.00         03000 ADULTS & PEDIATRICS         2,290,675         2,290,675         2,290,675         30.00           31.00         05000 (NEDISTRY CE COST CENTERS         26,689         31.00         30.00         30.00         30.000         10.020         30.00         30.000         30.000 (NTENS) EV CARE UNI T         26,689         31.00         30.00         31.00         30.000         30.000 (ADULLARY SERVICE COST CENTERS         30.00         31.00         30.00         31.00         30.00         31.00         30.00         31.00         30.00         31.00         30.00         31.00         30.00         31.00         30.00         31.00         30.00         31.00         30.00         31.00         30.00         31.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00			Titl	e XIX	Hospi tal		00 um
Linpati ent         Dutpati ent         Total (ccl. 6) + col. 7)         Cost of the Ratio         TEFRA Inpati ent Ratio           30.00         03000 ADULTS & PEDI ATRI CS         2,290,675         2,290,675         2,290,675         30.00         31.00           30.00         03000 ADULTS & PEDI ATRI CS         2,290,675         2,290,675         2,669         31.00           30.00         05400 (PERAT ING ROM         85,635         7,052,097         7,137,732         0.399033         0.0000000         54.00           54.00         05400 (PABLI NE COST CENTERS         427,430         15,822,095         16,249,525         0.170250         0.000000         54.00           60.00         06000 (MHOLE BLODD & PACKED RED BLODD CELLS         52,386         151,524         203,910         0.250611         0.000000         54.00           64.00         06000 (PHST ICA INFRAPY         1,497,878         7,75,928         9,273,806         0.312937         0.000000         65.00           65.00         06500 (PHST ICA INFRAPY         1,497,878         7,75,928         9,273,806         0.312937         0.000000         65.00           67.00         06700 OCUPATI MAL THERAPY         1,497,878         7,75,928         9,273,806         0.312937         0.000000         60.00							
Impart ent         Impact ent         Impact ent         Impact ent           30. 00         03000 ADULTS & PEDLATIRICS         2. 290, 675         2. 290, 675         30. 00         31. 00           31. 00         03000 (ADULTS & PEDLATIRICS         2. 290, 675         2. 290, 675         30. 00         31. 00           ANCILLARY SERVICE COST CENTERS         30. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00         31. 00	Cost Center Description	I npati ent		Total (col.	6 Cost or Other	TEFRA	
INPATIENT ROUTINE SERVICE COST CENTERS         Ratio         Ratio           30.00         03000 (ADULTS & FEDIARICS         2.290,675         2.990,675         30.00           ANCI LLARY SERVICE COST CENTERS         2.290,675         2.990,675         31.00           ANCI LLARY SERVICE COST CENTERS         2.290,675         2.6,689         31.00           ANCI LLARY SERVICE COST CENTERS         30.00         31.00           ANCI LLARY SERVICE COST CENTERS         31.00           ANCI LLARY SERVICE COST CENTERS         31.00           COSTOO (PERATINE ROOM         85,635         7,052,097         7,137,732         0.399033         0.000000         54.00           54.00         05400 (PADILDACY-DI AGNOSTI C         427,430         15,822,095         16,249,525         0.170250         0.000000         65.00           65.00         06200 (HADRATORY         795,890         13,472,912         14,268,802         0.312937         0.000000         65.00           66.00         06200 (RESPI RATORY THERAPY         1,497,878         7,775,928         9,273,806         0.31282         0.000000         65.00           66.00         06000 SPECH PATHOLOCY         0         0         0.000000         0.000000         67.00         0         0.000000         77.000						Inpati ent	
INPATIENT ROUTINE SERVICE COST CENTERS         2         2         2         2         2         2         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         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				Í			
30. 00         03000         ADULTS & PEDIATRICS         2,290,675         2,290,675         31.00         31.00           31. 00         03100         INTENSI VE CARE UNIT         26,689         26,689         31.00           30. 00         05000         OPERATI NG ROM         85,635         7,052,097         7,137,732         0.399033         0.000000         54.00           54.00         54000         RADOR ADI OLOCY-DI AGNOSTI C         427,430         15,822,095         16,249,525         0.170250         0.000000         54.03           60.00         GOOQ LABORATORY         795,890         13,472,912         14,268,802         0.312937         0.000000         62.00           65.00         065000         HEAPY         390,842         3,291,585         3,682,427         0.336611         0.000000         65.00           66.00         06000         PATHORY THERAPY         197,878         7,775,928         9,273,806         0.312327         0.000000         66.00         6600         600000         60.00         0         0.000000         66.00         60000         0.000000         0.000000         67.00         68.00         6800 SPECH PATHOLOGY         0         0         0.000000         67.00         67.00         69.00		6.00	7.00	8.00	9.00	10.00	
31.00         03100         INTENSIVE CARE UNIT         26,689         31.00           ANCILLARY SERVICE COST CENTERS	INPATIENT ROUTINE SERVICE COST CENTERS			·			
ANCILLARY SERVICE COST CENTERS           50:00         05000 OPERATI NG ROM         85,635         7,052,097         7,137,732         0.399033         0.000000         54.00           54:00         05400 RADI OLOGY-DI AGNOSTI C         427,430         15,822,095         16,249,525         0.170250         0.000000         54.00           54:01         05401 RUCLEAR MEDI CINE-DI AGNOSTI C         7,920         614,388         622,308         0.356637         0.000000         54.00           60:00         06000 LABORATORY         795,890         13,472,912         14,268,802         0.312937         0.000000         62.00           65:00         06500 RESPI RATORY THERAPY         390,842         3,291,585         3,682,427         0.336811         0.000000         65.00           66:00         06600 PHYSI CAL THERAPY         1,497,878         7,775,928         9,273,806         0.312382         0.000000         66.00           66:00         06300 SPECH PATHOLOGY         0         0         0         0.000000         0.000000         67.00           70:00         MOID CAL SUPPLIES CHARGED TO PATI ENT         324,212         541,168         33,921         0.482562         0.000000         72.00           71:00         07200 INUEA LAL SUPPLIES CHARGED TO PATI	30. 00 03000 ADULTS & PEDI ATRI CS	2, 290, 675		2, 290, 67	/5		30.00
50:00         OFERATING ROOM         85,635         7,052,097         7,137,732         0.399033         0.000000         54.00           54:00         05400         RADIOLOGY-DIAGNOSTIC         427,430         15,822,095         16,249,525         0.170250         0.000000         54.03           60:00         LABORATORY         795,890         13,472,912         14,268,802         0.312937         0.000000         62.00           62:00         06200         NUCLEAR MEDIOL NE-DI AGNOSTIC         7,920         614,388         622,308         0.356637         0.000000         62.00           62:00         06500         RESPI RATORY THERAPY         390,842         3,291,585         3,682,427         0.336811         0.000000         65.00           66:00         06600         PHYSI CAL THERAPY         1,497,878         7,775,928         9,273,806         0.312382         0.000000         66.00           66:00         06800         SPECH PATHOLOGY         0         0         0.000000         0.000000         67.00         67.00         60.00         0.000000         0.000000         68.00         0.800000         0.000000         68.00         0.000000         0.000000         7.00         7.00         7.00         7.00         7.00	31. 00 03100 I NTENSI VE CARE UNI T	26, 689		26, 68	39		31.00
54.00       05400       RADI OLOGY-DI AGNOSTI C       427, 430       15, 822, 095       16, 249, 525       0.170250       0.000000       54.00         54.03       05401       NUCLEAR MEDI CI NE-DI AGNOSTI C       7, 920       614, 388       622, 308       0.356637       0.000000       54.03         66.00       06000       LABORATORY       795, 890       13, 472, 912       14, 268, 802       0.312937       0.000000       62.00         65.00       06500       RESPI RATORY THERAPY       390, 842       3, 291, 585       3, 682, 427       0.336811       0.000000       65.00         66.00       06600       PHYSI CAL THERAPY       1, 497, 878       7, 775, 928       9, 273, 806       0.312382       0.000000       66.00         67.00       06700       0       0       0       0       0.000000       0.000000       68.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0.000000       0.000000       71.00         70.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       2, 412       431, 520       433, 932       0.405262       0.000000       73.00         70.00       07300       DRUGS CHARGED TO PATI ENTS       1, 683, 642       9, 829, 405	ANCILLARY SERVICE COST CENTERS						
54.03       05401       NUCLEAR MEDICINE-DIAGNOSTIC       7,920       614,388       622,308       0.356637       0.000000       54.03         60.00       06000       LABORATORY       795,890       13,472,912       14,268,802       0.312937       0.000000       62.00         65.00       06500       RESPI RATORY THERAPY       390,842       3,291,585       3,682,427       0.336811       0.000000       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0.000000       66.00         67.00       06700       OCUPATI ONAL THERAPY       0       0       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0.000000       0.000000       68.00         69.00       06900       LECTROCARDI OLOGY       0       0       0.000000       0.000000       71.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       334,221       554,106       888,327       1.082689       0.000000       72.00         73.00       07300       IMPL. DEV. CHARGED TO PATI ENTS       1.683,642       9,29,405       11,513,047       0.415465       0.000000       73.00         76.00       048801       RURAL HEALTH CL	50.00 O5000 OPERATING ROOM	85, 635	7, 052, 097	7, 137, 73	0. 399033	0. 000000	50.00
60.00       06000       LABORATORY       795,890       13,472,912       14,268,802       0.312937       0.000000       62.00         62.00       06500       RESPIRATORY THERAPY       52,386       151,524       203,910       0.250611       0.000000       62.00         66.00       06600       PHYSI CAL THERAPY       390,842       3.291,585       3.682,427       0.336811       0.000000       66.00         67.00       06700       OCCUPATI ONAL THERAPY       1,497,878       7,775,928       9,273,806       0.312382       0.000000       66.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0.000000       0.000000       66.000         69.00       06900       ELCTROCARDI OLOGY       0       0       0       0.000000       0.000000       71.00         07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       2,412       431,520       433,932       0.405262       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       1,683,642       9,829,405       11,513,047       0.415465       0.000000       73.00         76.00       038801       INFUSI NOT THERAPY       0       1,777,128       0.777,128       0.937639 <t< td=""><td>54.00 05400 RADI OLOGY-DI AGNOSTI C</td><td>427, 430</td><td>15, 822, 095</td><td>16, 249, 52</td><td>0. 170250</td><td>0. 000000</td><td>54.00</td></t<>	54.00 05400 RADI OLOGY-DI AGNOSTI C	427, 430	15, 822, 095	16, 249, 52	0. 170250	0. 000000	54.00
62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       52,386       151,524       203,910       0.250611       0.000000       62.00         65.00       06500       RESPI RATORY THERAPY       390,842       3,291,585       3,682,427       0.336811       0.000000       65.00         66.00       06400       PHYSICAL THERAPY       1,497,878       775,928       9,273,806       0.31232       0.00000       67.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       0.000000       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0.000000       0.000000       67.00         69.00       6400       HECROCARDI OLOGY       0       0       0       0.000000       71.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       2,412       431,520       433,932       0.405262       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       1,683,642       9,829,405       11,513,047       0.41545       0.000000       73.00         76.00       03480       INFUSI ON THERAPY       10,177,128       1,777,128       0.937639       0.0000000       70.	54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	7, 920	614, 388	622, 30	0. 356637	0. 000000	54.03
65.00       06500       RESPIRATORY THERAPY       390,842       3,291,585       3,682,427       0.336811       0.000000       65.00         66.00       06600       PHYSI CAL THERAPY       1,497,878       7,775,928       9,273,806       0.312382       0.000000       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0.000000       0.000000       68.00         68.00       06800       SPEECH PATHOLOGY       0       0       0.000000       0.000000       68.00         69.00       06700       CLORACAL SUPPLIES CHARGED TO PATIENT       334,221       554,106       888,327       1.082689       0.000000       72.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       2,412       431,520       433,932       0.405262       0.000000       73.00         73.00       07300       DRUGS CHARGED TO PATIENTS       1,683,642       9,829,405       11,513,047       0.415465       0.000000       73.00         70.00       DUTPATIENT SERVICE COST CENTERS       0       744,946       1.286590       0.000000       88.00         88.00       08801       RURAL HEALTH CLINIC I       0       1,777,128       1,777,128       0.337639       0.000000       90.001	60. 00 06000 LABORATORY	795, 890	13, 472, 912	14, 268, 80	0. 312937	0.000000	60.00
66.00       06600       PHYSI CAL THERAPY       1, 497, 878       7, 775, 928       9, 273, 806       0. 312382       0. 000000       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       0       0.000000       0. 000000       66.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0.000000       0.000000       67.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0.000000       0.000000       67.00         72.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       2,412       431,520       433,932       0.405262       0.000000       73.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       1,683,642       9,829,405       11,513,047       0.415465       0.000000       73.00         003800       RURAL HEALTH CLINIC       0       744,946       744,946       1.286590       0.000000       76.00         043801       NURAL HEALTH CLINIC       0       744,946       744,946       1.286590       0.000000       90.00         90.00       09000       CLINIC       0       744,946       744,946       1.286590       0.000000       90.00	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	52, 386	151, 524	203, 91	0 0. 250611	0.000000	62.00
67.00       06700       OCCUPATIONAL THERAPY       0       0       0       0.000000       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0.000000       0.000000       68.00         69.00       OCUPATIONAL THERAPY       0       0       0       0.000000       0.000000       68.00         71.00       007100       MEDICAL SUPPLIES CHARGED TO PATIENT       334,221       554,106       888,327       1.082689       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       2,412       431,520       433,932       0.405262       0.000000       72.00         76.00       03801       RURAL HEALTH CLINIC       1,683,642       9,829,405       11,513,047       0.415465       0.000000       76.00         04801       RURAL HEALTH CLINIC       0       744,946       744,946       1.286590       0.000000       88.00         88.00       08801       RURAL HEALTH CLINIC       0       1,777,128       1,777,128       0.937639       0.000000       90.01         90.01       09002       DIABETES       0       9,122       9,122       0.200395       0.0000000       90.01         90.02 </td <td>65. 00 06500 RESPI RATORY THERAPY</td> <td>390, 842</td> <td>3, 291, 585</td> <td>3, 682, 42</td> <td>0. 336811</td> <td>0. 000000</td> <td>65.00</td>	65. 00 06500 RESPI RATORY THERAPY	390, 842	3, 291, 585	3, 682, 42	0. 336811	0. 000000	65.00
68.00       06800       SPEECH PATHOLOGY       0       0       0       0.000000       0.000000       68.00         69.00       06900       ELECTROCARDIOLOGY       0       0       0       0.000000       0.000000       69.00         71.00       OT200       IMPL. DEV. CHARGED TO PATIENT       334,221       554,106       888,327       1.082689       0.000000       71.00         73.00       07300       DRUGS CHARGED TO PATIENTS       2,412       431,520       433,932       0.405262       0.000000       73.00         76.00       0380       INFUSION THERAPY       10,173       641,498       651,671       0.605833       0.000000       76.00         001PATIENT SERVICE COST CENTERS       0       744,946       744,946       1.286590       0.000000       88.00         88.00       0880       RURAL HEALTH CLINIC I       0       1,777,128       0.937639       0.000000       88.00         90.00       09000       CLINIC       0       9,122       9,122       0.200395       0.000000       90.03         90.01       09000       DIABETES       0       9,739       7,563,028       0.631611       0.000000       90.03         90.02       OPSYCH	66. 00 06600 PHYSI CAL THERAPY	1, 497, 878	7, 775, 928	9, 273, 80	0. 312382	0.000000	66.00
69.00       06900       ELECTROCARDIOLOGY       0       0       0       0.000000       0.000000       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       334,221       554,106       888,327       1.082689       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       2,412       431,520       433,932       0.405262       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       1,683,642       9,829,405       11,513,047       0.415465       0.000000       73.00         76.00       03480       INFUSION THERAPY       10,173       641,498       651,671       0.605833       0.000000       76.00         0UTPATIENT SERVICE COST CENTERS       0       744,946       744,946       1.286590       0.000000       88.00         88.01       0800       RURAL HEALTH CLINIC II       0       1,777,128       0.937639       0.000000       88.00         90.00       09000       CLINIC       0       9,122       9,122       0.200395       0.000000       90.02         90.02       OP SYCH       0       0       0       0       0       0.000000       0.000000       90.02	67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0.000000	0. 000000	67.00
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       334, 221       554, 106       888, 327       1.082689       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       2, 412       431, 520       433, 932       0.405262       0.000000       72.00         73.00       O7300       DRUGS CHARGED TO PATIENTS       1, 683, 642       9, 829, 405       11, 513, 047       0.415465       0.000000       73.00         76.00       03480       INFUSION THERAPY       10, 173       641, 498       651, 671       0.605833       0.000000       76.00         0UTPATIENT SERVICE COST CENTERS       0       744, 946       744, 946       1.286590       0.000000       88.00         88.00       08800       RURAL HEALTH CLINIC       0       1, 777, 128       1, 777, 128       0.937639       0.000000       88.01         90.01       09000       CLINC       0       9, 122       9, 122       0.2037639       0.000000       90.01         90.02       OPOSO CLINIC       0       9, 122       9, 122       0, 2003900       0.000000       90.01       90.00       90.00       0.000000       90.00       90.03       900.03       900.03       900.03       900.03       91.	68.00 06800 SPEECH PATHOLOGY	0	0		0 0.000000	0.000000	68.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       2,412       431,520       433,932       0.405262       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       1,683,642       9,829,405       11,513,047       0.415465       0.000000       73.00         76.00       03480       INFUSION THERAPY       10,173       641,498       651,671       0.605833       0.000000       76.00         0UTPATIENT SERVICE COST CENTERS       0       744,946       744,946       1.286590       0.000000       88.00         88.00       08801       RURAL HEALTH CLINIC       0       1,777,128       1,777,128       0.937639       0.000000       90.000       90.00       90.00       90.00       90.00       90.00       0       0       413,742       413,742       0.341164       0.000000       90.00       90.00       90.00       90.00       90.00       90.00       90.000       90.000       90.000       90.000       90.000       90.000       90.000       90.000       90.000       90.000       90.000       90.000       90.000       90.000       90.000       90.000       90.000       90.000       90.000       90.000       90.000       90.000       90.000       90.000	69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0.000000	0. 000000	69.00
73.00       07300       DRUGS CHARGED TO PATIENTS       1,683,642       9,829,405       11,513,047       0.415465       0.000000       73.00         76.00       03480       INFUSION THERAPY       10,173       641,498       651,671       0.605833       0.000000       76.00         0UTPATIENT SERVICE COST CENTERS       0       744,946       744,946       1.286590       0.000000       88.00         88.00       08800       RURAL HEALTH CLINIC II       0       1,777,128       0.937639       0.000000       88.01         90.00       09000       CLINIC       0       413,742       413,742       0.341164       0.000000       90.00         90.01       09001       DI ABETES       0       9,122       9,122       0.200395       0.000000       90.02         90.02       09002       OP PSYCH       0       0       0       0.000000       90.02         90.03       09003       PAIN MANAGEMENT       0       247,889       247,889       2.357245       0.000000       90.03         91.00       O9100       EMERGENCY       253,689       7,309,339       7,563,028       0.631611       0.000000       92.00         92.00       092200       0BSERVATION BEDS (NON-DIS	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	334, 221	554, 106	888, 32	1. 082689	0.000000	71.00
76. 00       03480       INFUSION THERAPY       10, 173       641, 498       651, 671       0. 605833       0. 000000       76. 00         0UTPATIENT SERVICE COST CENTERS	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 412	431, 520	433, 93	0. 405262	0.000000	72.00
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         0         744,946         744,946         1.286590         0.000000         88.00           88.01         08801         RURAL HEALTH CLINIC II         0         1,777,128         1,777,128         0.937639         0.000000         88.01           90.00         09000 CLINIC         0         413,742         413,742         0.341164         0.000000         90.00           90.01         09001 DI ABETES         0         9,122         9,122         0.200395         0.000000         90.01           90.02         09002 OP PSYCH         0         0         247,889         247,889         2.357245         0.000000         90.03           90.03         09003 PAIN MANAGEMENT         0         247,889         2.357245         0.000000         90.03           91.00         09100 EMERGENCY         253,689         7,309,339         7,563,028         0.631611         0.0000000         92.00           92.00         09200 OBSERVATI ON BEDS (NON-DI STINCT PART         61,182         1,058,371         1,119,553         1.620881         0.000000         92.00           92.01.00         INTEREST EXPENSE         0         920,372         <	73.00 07300 DRUGS CHARGED TO PATIENTS	1, 683, 642	9, 829, 405	11, 513, 04	0. 415465	0.000000	73.00
88.00       08800       RURAL HEALTH CLINIC       0       744,946       744,946       1.286590       0.000000       88.00         88.01       08801       RURAL HEALTH CLINIC II       0       1,777,128       1,777,128       0.937639       0.000000       88.01         90.00       09000       CLINIC       0       413,742       413,742       0.341164       0.000000       90.00         90.01       09001       DIABETES       0       9,122       9,122       0.200395       0.000000       90.01         90.02       09002       OP PSYCH       0       0       0       0.000000       90.02         90.03       09003       PAIN       MANAGEMENT       0       247,889       247,889       2.357245       0.000000       90.02         91.00       09100       EMERGENCY       253,689       7,309,339       7,563,028       0.631611       0.000000       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       61,182       1,058,371       1,119,553       1.620881       0.000000       92.00         92.01       0       920,372       920,372       920,372       101.00       92.00          0       920,372 <td>76.00 03480 INFUSION THERAPY</td> <td>10, 173</td> <td>641, 498</td> <td>651, 67</td> <td>0. 605833</td> <td>0.000000</td> <td>76.00</td>	76.00 03480 INFUSION THERAPY	10, 173	641, 498	651, 67	0. 605833	0.000000	76.00
88.01       08801       RURAL HEALTH CLINICII       0       1,777,128       1,777,128       0.937639       0.000000       88.01         90.00       09000       CLINIC       0       413,742       413,742       0.341164       0.000000       90.00         90.01       09001       DLABETES       0       9,122       9,122       0.200395       0.000000       90.01         90.02       09002       OP PSYCH       0       0       0       0.000000       90.02         90.03       09003       PALN MANAGEMENT       0.247,889       247,889       2.357245       0.000000       90.03         91.00       09100       EMERGENCY       253,689       7,309,339       7,563,028       0.631511       0.000000       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       61,182       1,058,371       1,119,553       1.620881       0.000000       92.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       61,182       1,058,371       1,119,553       1.620881       0.000000       92.00         92.01       0       920,372       920,372       920,372       101.00       101.00       101.00       101.00       113.00       11300 <td>OUTPATIENT SERVICE COST CENTERS</td> <td></td> <td></td> <td>·</td> <td></td> <td></td> <td></td>	OUTPATIENT SERVICE COST CENTERS			·			
90. 00       09000       CLINIC       0       413,742       413,742       0.341164       0.00000       90.00         90. 01       09001       DI ABETES       0       9,122       9,122       0.200395       0.000000       90.01         90. 02       09002       OP PSYCH       0       0       0       0       0.000000       90.02         90. 03       09003       PAI N MANAGEMENT       0       247,889       247,889       2.357245       0.000000       90.03         91. 00       09100       EMERGENCY       253,689       7,309,339       7,563,028       0.631611       0.000000       91.00         92. 00       09200       0BSERVATION       BEDS (NON-DI STINCT PART       61,182       1,058,371       1,119,553       1.620881       0.000000       92.00         92. 00       09200       0BSERVATION       BEDS (NON-DI STINCT PART       61,182       1,058,371       1,119,553       1.620881       0.000000       92.00         92. 00       OTHER       REI MBURSABLE COST CENTERS       0       920,372       920,372       101.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00	88.00 08800 RURAL HEALTH CLINIC	0	744, 946	744, 94	1. 286590	0.000000	88.00
90.01       09001       DI ABETES       0       9,122       9,122       0.200395       0.00000       90.01         90.02       09002       OP PSYCH       0       0       0       0.000000       0.000000       90.02         90.03       09003       PAI N MANAGEMENT       0       247,889       247,889       2.357245       0.000000       90.03         91.00       09100       EMERGENCY       253,689       7,309,339       7,563,028       0.631611       0.000000       91.00         92.00       09SERVATI ON BEDS (NON-DI STINCT PART       61,182       1,058,371       1,119,553       1.620881       0.000000       92.00         92.00       0BSERVATI ON BEDS (NON-DI STINCT PART       61,182       1,058,371       1,119,553       1.620881       0.000000       92.00         92.00       OTHER REI MBURSABLE COST CENTERS       0       920,372       0       92.00       92.00       92.01       92.01       92.01       92.01       92.01       92.00       92.01       92.01       92.01       92.01       92.00       92.00       92.01       92.01       92.01       92.01       92.00       92.00       92.01       92.01       92.02       92.02       92.02       92.02       92.0	88.01 08801 RURAL HEALTH CLINIC II	0	1, 777, 128	1, 777, 12	0. 937639	0. 000000	88.01
90. 02       09 002       0P PSYCH       0       0       0       0.000000       0.000000       90. 02         90. 03       09003       PAI N MANAGEMENT       0       247, 889       2.47, 889       2.357245       0.000000       90. 03         91. 00       09100       EMERGENCY       253, 689       7, 309, 339       7, 563, 028       0.631611       0.000000       91. 00         92. 00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART       61, 182       1, 058, 371       1, 119, 553       1.620881       0.000000       92. 00         0THER REI MBURSABLE COST CENTERS       0       920, 372       920, 372       101. 00         10100       HOME HEALTH AGENCY       0       920, 372       920, 372       101. 00         SPECIAL PURPOSE COST CENTERS       113. 00       11300       INTEREST EXPENSE       200. 00       200. 00       201. 00       200. 00       201. 00       200. 00       201. 00       201. 00       200. 00       201. 00       200. 00       201. 00       201. 00       0       201. 00       201. 00       201. 00       201. 00       201. 00       201. 00       201. 00       201. 00       201. 00       201. 00       201. 00       201. 00	90. 00 09000 CLINIC	0	413, 742	413, 74	0. 341164	0. 000000	90.00
90.03       09003       PAIN MANAGEMENT       0       247,889       2.357245       0.000000       90.03         91.00       09100       EMERGENCY       253,689       7,309,339       7,563,028       0.631611       0.000000       91.00         92.00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART       61,182       1,058,371       1,119,553       1.620881       0.000000       92.00         OTHER REIMBURSABLE COST CENTERS         101.00         SPECIAL PURPOSE COST CENTERS         113.00       1NTEREST EXPENSE       113.00       NUTHERST EXPENSE       113.00       200.00       201.00       200.00       201.00       200.00       201.00       201.00       200.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00	90. 01 09001 DI ABETES	0	9, 122	9, 12	0. 200395	0. 000000	90.01
91.00       09100       EMERGENCY       253, 689       7, 309, 339       7, 563, 028       0.631611       0.000000       91.00         92.00       09200       0BSERVATION BEDS (NON-DISTINCT PART       61, 182       1, 058, 371       1, 119, 553       1.620881       0.000000       92.00         0THER       REI MBURSABLE COST CENTERS       0       920, 372       920, 372       920, 372       101.00         101.00       HOME HEALTH AGENCY       0       920, 372       920, 372       101.00       101.00         SPECIAL PURPOSE COST CENTERS         113.00       11300       INTEREST EXPENSE       113.00       200.00       200.00       200.00       200.00       200.00       200.00       200.00       200.00       200.00       200.00       200.00       200.00       200.00       200.00       200.00       200.00       200.00       200.00       200.00       200.00       200.00       200.00       201.00       200.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00	90. 02 09002 OP PSYCH	0	0		0 0.000000	0. 000000	90.02
92. 00         09200         0BSERVATION         BEDS         (NON-DISTINCT PART         61, 182         1, 058, 371         1, 119, 553         1. 620881         0. 000000         92. 00           OTHER         REI MBURSABLE         COST         CENTERS         101. 00         10100         HOME         HEALTH         AGENCY         0         920, 372         920, 372         101. 00           SPECIAL         PURPOSE         COST         CENTERS         113. 00         11300         INTEREST         EXPENSE         113. 00         200. 00         200. 00         200. 00         200. 00         200. 00         201. 00         Less         0bservation         200. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201	90. 03 09003 PALN MANAGEMENT	0	247, 889	247, 88	2. 357245	0. 000000	90.03
OTHER         REI MBURSABLE         COST         CENTERS           101.00         10100         HOME         HEALTH         AGENCY         0         920, 372         920, 372         101.00           SPECI AL         PURPOSE         COST         CENTERS         113.00         1NTEREST         EXPENSE         113.00         200.00         Subtotal         (see instructions)         7, 920, 664         72, 117, 967         80, 038, 631         200.00         201.00	91.00 09100 EMERGENCY	253, 689	7, 309, 339	7, 563, 02	0. 631611	0. 000000	91.00
101.00       10100       HOME       HEALTH       AGENCY       0       920, 372       920, 372       101.00         SPECIAL       PURPOSE       COST       CENTERS       113.00       11300       INTEREST       EXPENSE       113.00       200.00       Subtotal       (see instructions)       7, 920, 664       72, 117, 967       80, 038, 631       200.00       201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	61, 182	1, 058, 371	1, 119, 55	1. 620881	0. 000000	92.00
SPECIAL PURPOSE COST CENTERS           113.00         11300         INTEREST EXPENSE           200.00         Subtotal (see instructions)         7,920,664         72,117,967         80,038,631         200.00           201.00         Less Observation Beds         7,920,664         72,117,967         80,038,631         200.00	OTHER REIMBURSABLE COST CENTERS			·			
113.00       11300       INTEREST EXPENSE       113.00         200.00       Subtotal (see instructions)       7,920,664       72,117,967       80,038,631       200.00         201.00       Less Observation Beds       7,920,664       72,117,967       80,038,631       200.00	101.00 10100 HOME HEALTH AGENCY	0	920, 372	920, 37	2		101.00
200.00         Subtotal (see instructions)         7,920,664         72,117,967         80,038,631         200.00           201.00         Less Observation Beds         201.00         201.00         201.00         201.00							
201.00 Less Observation Beds 201.00	113.0011300 INTEREST EXPENSE						113.00
	200.00 Subtotal (see instructions)	7, 920, 664	72, 117, 967	80, 038, 63	31		200.00
202.00           Total (see instructions)         7, 920, 664         72, 117, 967         80, 038, 631         202.00	201.00 Less Observation Beds						201.00
	202.00   Total (see instructions)	7, 920, 664	72, 117, 967	80, 038, 63	31		202.00

Health Financial Systems	DEACONESS G	I BSON	In Lieu	」of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1319	Period: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Pr 2/28/2022 10	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	I				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATI NG ROOM	0. 000000				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000				54.03
60. 00 06000 LABORATORY	0. 000000				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76.00 03480 INFUSION THERAPY	0. 000000				76.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0. 000000				88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000				88.01
90. 00 09000 CLINIC	0. 000000				90.00
90. 01 09001 DI ABETES	0. 000000				90.01
90. 02 09002 OP PSYCH	0. 000000				90.02
90. 03 09003 PALN MANAGEMENT	0. 000000				90.03
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00
					•

Health Financial Systems	DEACONESS	GI BSON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		Period: From 10/01/2020 To 09/30/2021	Worksheet D Part II Date/Time Pre 2/28/2022 10:	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)	-		
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	229, 178	7, 137, 732	0. 03210	08 11, 061	355	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	170, 189	16, 249, 525	0. 01047	/3 67, 864	711	54.00
54.03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	17, 232	622, 308	0. 02769	0 0	0	54.03
60. 00 06000 LABORATORY	95, 959	14, 268, 802	0. 00672	25 146, 116	983	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	265	203, 910	0.00130	13, 725	18	62.00
65. 00 06500 RESPI RATORY THERAPY	76, 709	3, 682, 427	0. 02083	81 88, 195	1, 837	65.00
66. 00 06600 PHYSI CAL THERAPY	156, 569	9, 273, 806	0. 01688	33 56, 471	953	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0. 00000	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0. 00000	0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0	0. 00000	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	141, 024	888, 327	0. 15875	52 59, 352	9, 422	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	742	433, 932	0. 00171	0 75	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	78, 082	11, 513, 047	0. 00678	304, 209	2,063	73.00
76.00 03480 INFUSION THERAPY	44, 454	651, 671	0. 06821	5 636	43	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	3, 765	744, 946	0.00505	64 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	61, 907	1, 777, 128	0. 03483	35 0	0	88.01
90. 00 09000 CLINIC	1, 727	413, 742	0.00417	<sup>7</sup> 4 0	0	90.00
90. 01 09001 DI ABETES	12	9, 122	0.00131	6 0	0	90.01
90. 02 09002 OP PSYCH	0		1	0 0	0	90.02
90. 03 09003 PALN MANAGEMENT	64, 395	247, 889			0	90.03
91.00 09100 EMERGENCY	337, 480				833	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	163, 506				758	
200.00   Total (lines 50 through 199)	1, 643, 195			771, 552		

Health Financial Systems	DEACONESS	GI BSON		In Li	eu of Form CMS-3	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS	S Provider CC	CN: 15-1319	Period: From 10/01/202 To 09/30/202		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
'	Anesthetist	Program	Program	Post-Stepdowr	n	
	Cost	Post-Stepdown	5	Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS	1				-	
50.00 05000 OPERATING ROOM	0	0		0	0 0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0 0	54.00
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0	0 0	54.03
60. 00 06000 LABORATORY	0	0		0	0 0	60,00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0 0	62,00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0 0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	ol o	
68.00 06800 SPEECH PATHOLOGY	0	0		0	ol o	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	ol o	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	ol o	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0 0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0 0	
76.00 03480 I NFUSI ON THERAPY	0	0		0	ol o	76.00
OUTPATIENT SERVICE COST CENTERS		-		-	-1 -	
88.00 08800 RURAL HEALTH CLINIC	0	0		0	0 0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0	0 0	
90. 00 09000 CLINIC	0	0		0	0 0	90.00
90. 01 09001 DI ABETES	0	0		0	0 0	90.01
90. 02 09002 OP PSYCH	0	0		0		90.02
90. 03 09003 PALN MANAGEMENT	0	0		0	0 0	90.03
91. 00 09100 EMERGENCY	0	0		0	0 0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0	
200.00 Total (lines 50 through 199)	0	0		0	-	200.00
	-1	-	1	1		

Health Financial Systems	DEACONESS	GIBSON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 10/01/2020 To 09/30/2021		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS	1		-			
50.00 05000 OPERATI NG ROOM	0	0		0 7, 137, 732		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 16, 249, 525		54.00
54. 03 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	0		0 622, 308		54.03
60. 00 06000 LABORATORY	0	0		0 14, 268, 802		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 203, 910		62.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 3, 682, 427		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 9, 273, 806	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 888, 327		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 433, 932	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 11, 513, 047	0.000000	73.00
76.00 03480 INFUSION THERAPY	0	0		0 651, 671	0.00000	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 744, 946	0.000000	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 1, 777, 128	0.000000	88.01
90. 00 09000 CLINIC	0	0		0 413, 742	0.000000	90.00
90. 01 09001 DI ABETES	0	0		0 9, 122	0.000000	90.01
90. 02 09002 OP PSYCH	0	0		0 0	0.000000	90.02
90. 03 09003 PALN MANAGEMENT	0	0		0 247, 889		90.03
91.00 09100 EMERGENCY	0	0		0 7, 563, 028	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 1, 119, 553	0.000000	92.00
200.00   Total (lines 50 through 199)	0	0		0 76, 800, 895		200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS         Provider CCN: 15-1319         Period: From 10/01/2020 To 09/30/2021         Worksheet D Part IV Date/Time Prepare 2/28/2022 10:06 a           V         Title XVIII         Hospital         Cost         Cost         Cost         Cost         Utpatient Program         Outpatient Program	-10
Cost Center Description       Outpatient Ratio of Cost to Charges (col. 6 + col. 7)       Inpatient Program Charges       Inpatient Program Charges       Outpatient Program Charges       Outpatient Program<	
Ratio of Cost to Charges (col. 6 + col. 7)         Program Charges         Program Pass-Through Costs (col. 8 x col. 10)         Program Charges         Program Pass-Through Costs (col. 9 x col. 12)           ANCI LLARY SERVICE COST CENTERS         9.00         10.00         11.00         12.00         13.00           50.00         05000 OPERATI NG ROOM         0.000000         11,061         0         0         50.           54.00         05400 RADI OLOGY-DI AGNOSTI C         0.000000         67,864         0         0         0         54.           54.03         05401 NUCLEAR MEDI CI NE-DI AGNOSTI C         0.000000         0         0         0         54.	
to Charges (col. 6 ÷ col. 7)         Charges (col. 6 ÷ col. 7)         Pass-Through Costs (col. 8 x col. 10)         Charges Costs (col. 9 x col. 12)         Pass-Through Costs (col. 9 x col. 12)           ANCI LLARY SERVICE COST CENTERS         9.00         10.00         11.00         12.00         13.00           50.00         05000         OPERATI NG ROOM         0.000000         11,061         0         0         50.00           54.00         05400         NUCLEAR MEDI CI NE-DI AGNOSTI C         0.000000         67,864         0         0         0         54.00           54.03         05401         NUCLEAR MEDI CI NE-DI AGNOSTI C         0.000000         0         0         0         54.00	
ANCI LLARY SERVICE COST CENTERS         Costs (col. 8 col. 7)         Costs (col. 8 x col. 10)         Costs (col. 9 x col. 12)           50.00         05000         0PERATI NG ROOM         0.000000         11.00         12.00         13.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         0.000000         67, 864         0         0         0         54.00           54.03         05401         NUCLEAR MEDI CI NE-DI AGNOSTI C         0.000000         0         0         0         54.00	
Image: col region         col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col region         x col regi	
ANCI LLARY SERVICE COST CENTERS         9.00         10.00         11.00         12.00         13.00           50.00         05000         OPERATING ROOM         0.000000         11,061         0         0         50.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         0.000000         67,864         0         0         54.00         54.00         05401         NUCLEAR MEDI CI NE-DI AGNOSTI C         0.000000         67,864         0         0         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00	
ANCI LLARY         SERVICE         COST         CENTERS           50.00         05000         OPERATI NG         ROOM         0.000000         11,061         0         0         0         50.           54.00         05400         RADI OLOGY-DI AGNOSTI C         0.000000         67,864         0         0         0         54.           54.03         05401         NUCLEAR         MEDI CI NE-DI AGNOSTI C         0.000000         0         0         0         0         54.	
50. 00         05000         OPERATI NG_ROOM         0. 00000         11, 061         0         0         50.           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0. 000000         67, 864         0         0         0         54.           54. 03         05401         NUCLEAR MEDI CI NE-DI AGNOSTI C         0. 000000         67, 864         0         0         0         54.	
54.00         05400         RADI OLOGY-DI AGNOSTI C         0.000000         67, 864         0         0         0         54.00         54.00         0         0         54.00         54.00         0         0         54.00         54.00         0         0         54.00         0         0         54.00         54.00         0         0         54.00         54.00         0         0         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00	
54. 03 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C 0. 000000 0 0 0 54.	
	. 03
60. 00 06000 LABORATORY 0. 00000 146, 116 0 0 0 0 60.	. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 13,725 0 0 0 62.	. 00
65. 00 06500 RESPI RATORY THERAPY 0. 00000 88, 195 0 0 0 65.	. 00
66. 00 06600 PHYSI CAL THERAPY 0. 00000 56, 471 0 0 0 66.	. 00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 00000 0 0 0 0 67.	. 00
68.00 06800 SPEECH PATHOLOGY 0.00000 0 0 0 68.	. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 00000 0 0 0 69.	. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 000000 59, 352 0 0 0 71.	. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 000000 75 0 0 0 72.	. 00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 304, 209 0 0 73.	. 00
76.00 03480 INFUSION THERAPY 0.00000 636 0 0 0 76.	. 00
OUTPATIENT SERVICE COST CENTERS	
88. 00 08800 RURAL HEALTH CLINIC 0. 000000 0 0 0 88.	. 00
88. 01 08801 RURAL HEALTH CLINIC II 0. 000000 0 0 0 88.	. 01
90. 00 09000 CLINIC 0. 00000 0 0 0 0 0 90.	. 00
90. 01 09001 DI ABETES 0. 00000 0 0 0 0 0 90.	. 01
90. 02 09002 0P PSYCH 0. 00000 0 0 0 0 0 0 90.	. 02
90. 03 09003 PALN MANAGEMENT 0. 00000 0 0 0 0 0 90.	. 03
91.00 09100 EMERGENCY 0.00000 18,658 0 0 0 91.	. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 5, 190 0 0 0 92.	. 00
200.00         Total (lines 50 through 199)         771,552         0         0         0         200.	. 00

Health Financial Systems	DEACONESS	GI BSON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od:	Worksheet D	
				From 10/01/2020 To 09/30/2021	Part V	norod.
				10 09/30/2021	Date/Time Pre 2/28/2022 10:	06 am
		Title	XVIII	Hospi tal	Cost	<u></u>
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0.000000		0.005.75	(	0	50.00
50. 00 05000 OPERATING ROOM	0. 399033		_,,		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 170250		4,034,57		0	54.00
54. 03 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	0. 356637		183, 85		0	54.03
	0. 312937		2, 588, 69		0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 250611		24,07		0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 336811		1,001,93		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 312382		1, 789, 92	5 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000			0 0	0	67.00 68.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0. 000000 0. 000000			0 0	0	68.00
			172.04		0	71.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	1. 082689 0. 405262		173, 04		-	72.00
72.00 07200 TMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0. 405262		151, 21 3, 796, 77		0	72.00
73. 00 07300 DRUGS CHARGED TO PATTENTS 76. 00 03480 I NFUSI ON THERAPY	0. 415465		3, 798, 77		0	76.00
OUTPATIENT SERVICE COST CENTERS	0. 000655	0	224, 30	2 0	0	70.00
88.00 08800 RURAL HEALTH CLINIC		1	1			88.00
88. 01 08801 RURAL HEALTH CLINIC II						88.01
90. 00 09000 CLINIC	0. 341164	0	151, 38	7 0	0	90.00
90. 01 09001 DI ABETES	0. 200395		2, 62		0	90.01
90. 02 09002 0P PSYCH	0. 000000			0 0	0	
90. 03 09003 PALN MANAGEMENT	2. 357245		75, 46		0	90.03
91. 00 09100 EMERGENCY	0. 631611		1, 367, 18		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 620881		300, 15		0	
200.00 Subtotal (see instructions)		0	18, 090, 94		0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	18, 090, 94	9 272	0	202.00

Health Financial Systems	DEACONESS	GI BSON		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1319	Period: From 10/01/2020 To 09/30/2021	Worksheet D Part V Date/Time Pre 2/28/2022 10:	epared: 06 am
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	888, 150	0				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	686, 887	0				54.00
54.03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	65, 569	0				54.03
60. 00 06000 LABORATORY	810, 097	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	6, 032	0				62.00
65. 00 06500 RESPI RATORY THERAPY	337, 462	0				65.00
66.00 06600 PHYSI CAL THERAPY	559, 140	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	187, 353	0				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	61, 281	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 577, 427	107				73.00
76.00 03480 INFUSION THERAPY	135, 890	0				76.00
OUTPATIENT SERVICE COST CENTERS			•			
88.00 08800 RURAL HEALTH CLINIC						88.00
88.01 08801 RURAL HEALTH CLINIC II						88.01
90. 00 09000 CLINIC	51, 648	0				90.00
90. 01 09001 DI ABETES	525	0				90.01
90.02 09002 OP PSYCH	0	0				90.02
90. 03 09003 PALN MANAGEMENT	177, 894	0				90.03
91.00 09100 EMERGENCY	863, 526	9				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	486, 516	0				92.00
200.00 Subtotal (see instructions)	6, 895, 397	116				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						1
202.00 Net Charges (line 200 - line 201)	6, 895, 397	116				202.00

JMPUT.	Financial Systems DEACOM ATION OF INPATIENT OPERATING COST	VESS GIBSON Provider CCN: 15-1319	Peri od:	Worksheet D-1	2552
			From 10/01/2020 To 09/30/2021	Date/Time Pre 2/28/2022 10:0	
	Cost Castor Description	Title XVIII	Hospi tal	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	Inpatient days (including private room days and swing-b			3, 286	
00	Inpatient days (including private room days, excluding			1, 629	
00	Private room days (excluding swing-bed and observation do not complete this line.	bed days). If you have only p	rivate room days,	0	3.
00	Semi-private room days (excluding swing-bed and observa			783	
00	Total swing-bed SNF type inpatient days (including priv reporting period	vate room days) through Decemb	er 31 of the cost	330	5
00	Total swing-bed SNF type inpatient days (including priv		31 of the cost	600	6
00	reporting period (if calendar year, enter 0 on this lin		- 01 -6 +6+		_
00	Total swing-bed NF type inpatient days (including priva reporting period	ate room days) through Decembe	r 31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including priva		31 of the cost	727	8
00	reporting period (if calendar year, enter 0 on this lin Total inpatient days including private room days applic		a swina-bed and	315	9
00	newborn days) (see instructions)	0	0 0	515	
. 00	Swing-bed SNF type inpatient days applicable to title X	5 ( 51	room days)	330	10
. 00	through December 31 of the cost reporting period (see i Swing-bed SNF type inpatient days applicable to title X		room days) after	600	11
	December 31 of the cost reporting period (if calendar y	year, enter 0 on this line)			
2.00	Swing-bed NF type inpatient days applicable to titles V through December 31 of the cost reporting period	or XIX only (including priva	te room days)	0	12
8.00	Swing-bed NF type inpatient days applicable to titles V			0	13
. 00	after December 31 of the cost reporting period (if cale Medically necessary private room days applicable to the	endar year, enter 0 on this li	ne)	0	14
. 00	Total nursery days (title V or XIX only)	e Program (excruding swing-bed	uays)	0	1 .
	Nursery days (title V or XIX only)			0	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to	services through December 31	of the cost		117
	reporting period	Services through becember of			
8.00	Medicare rate for swing-bed SNF services applicable to reporting period	services after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to s	services through December 31 o	f the cost	216. 95	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to s	services after December 31 of	the cost	216. 95	20
. 00	reporting period Total general inpatient routine service cost (see instr	auctions)		5, 646, 753	21
	Swing-bed cost applicable to SNF type services through		ting period (line		22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after De	combor 21 of the east reporti	ng partial (line (	0	23
. 00	x line 18)	cember 31 01 the cost report	ng period (inne o	0	2
. 00	Swing-bed cost applicable to NF type services through D $7 \times 1$ ine 19)	December 31 of the cost report	ing period (line	0	24
. 00	Swing-bed cost applicable to NF type services after Dec	cember 31 of the cost reportin	g period (line 8	157, 723	25
	x line 20)				
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed	l cost (line 21 minus line 26)		2, 152, 564 3, 494, 189	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding sw Private room charges (excluding swing-bed charges)	ving-bed and observation bed c	harges)	0	
	Semi -private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (li	ne 27 ÷ line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ li			0.00 0.00	
	Average per diem private room charge differential (line	-	ctions)	0.00	
	Average per diem private room cost differential (line 3			0.00	
. 00 . 00	Private room cost differential adjustment (line 3 x lin General inpatient routine service cost net of swing-bed		ifferential (line	0 3, 494, 189	
	27 minus line 36)			3, 1, 1, 10,	Ľ
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH CO				-
				2, 144. 99	38
	Adjusted general inpatient routine service cost per die	m (see instructions)	1	2, 144. 77	1 00
3.00	Adjusted general inpatient routine service cost per die Program general inpatient routine service cost (line 9 Medically necessary private room cost applicable to the	x line 38)		675, 672 0	39

COMPUTATION OF INPATIENT OPERATING COST       Provider CCN: 15-1319       Period: From 10/01/2020 To 09/30/2021       Worksheet D-1         Computation       Title XVIII       Hospital       Cost         Cost Center Description       Total Inpatient       Total Days       Average Per Diem (col. 1       Program Days (col. 3 x       Program Cost (col. 3 x         42.00       NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units       Units       43.00       INTENSIVE CARE UNIT       243,982       21       11,618.19       8       92,946	epared:
Total     Total     Average Per     Program Days     Program Cost       Cost     Inpatient     Inpatient     Days     ÷ col. 2)     etcl. 4)       42.00     NURSERY (title V & XIX only)     Intensive Care Type Inpatient Hospital Units	
Inpatient     Inpatient     Diem (col. 1     (col. 3 x       Cost     Days     ÷ col. 2)     col. 4)       1.00     2.00     3.00     4.00       42.00     NURSERY (title V & XIX only)	
1.00         2.00         3.00         4.00         5.00           42.00         NURSERY (title V & XIX only)         Intensive Care Type Inpatient Hospital Units         Intensive Care Type Inpatient Hospital Units	
Intensive Care Type Inpatient Hospital Units	
	42.00
	43.00
44. 00 CORONARY CARE UNIT	43.00
45.00 BURN INTENSIVE CARE UNIT	45.00
46. OO SURGI CAL I NTENSI VE CARE UNI T	46.00
47. 00 OTHER SPECIAL CARE (SPECIFY)	47.00
Cost Center Description 1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 323,739	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48) (see instructions) 1,092,357	1
PASS THROUGH COST ADJUSTMENTS	
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and 0	50.00
III) 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II) 0	51.00
and IV)	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51) 0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 0	53.00
medical education costs (line 49 minus line 52)	
TARGET AMOUNT AND LIMIT COMPUTATION         54. 00       Program di scharges       0	54.00
55. 00 Target amount per discharge 0.00	
56.00 Target amount (line 54 x line 55) 00	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0	
58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the 0.00	
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the 0.00 market basket	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by	61.00
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	
62.00 Relief payment (see instructions)	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)	
PROGRAM INPATIENT ROUTINE SWING BED COST	
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 707, 847	64.00
instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See 1,286,994	65.00
instructions) (title XVIII only)	00.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For 1,994,841	66.00
CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period 0	67.00
(line 12 x line 19)	07.00
	68.00
(line 13 x line 20)	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	69.00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	71.00
72.00 Program routine service cost (line 9 x line 71)	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column	74.00
26, line 45)	
76.00 Per diem capital-related costs (line 75 ÷ line 2)	76.00
77.00 Program capital-related costs (line 9 x line 76)	77.00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records)	78.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	80.00
81.00 Inpatient routine service cost per diem limitation	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)	82.00
83.00 Reasonable inpatient routine service costs (see instructions)	83.00
<ul><li>84.00 Program inpatient ancillary services (see instructions)</li><li>85.00 Utilization review - physician compensation (see instructions)</li></ul>	84.00 85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	
87.00 Total observation bed days (see instructions) 846	1
88.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)2,144.9989.00Observation bed cost (line 87 x line 88) (see instructions)1,814,662	
	1 37.00

Health Financial Systems	DEACONESS	GI BSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 10/01/2020	Worksheet D-1	
				To 09/30/2021	Date/Time Pre 2/28/2022 10:	pared: 06 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	508, 792	5, 646, 753	0.09010	3 1, 814, 662	163, 506	90.00
91.00 Nursing Program cost	0	5, 646, 753	0.00000	0 1, 814, 662	0	91.00
92.00 Allied health cost	0	5, 646, 753	0.00000	0 1, 814, 662	0	92.00
93.00 All other Medical Education	0	5, 646, 753	0.00000	1, 814, 662	0	93.00

	Financial Systems DEACONES ATION OF INPATIENT OPERATING COST	S GIBSON Provider CCN: 15-1319	Period:	u of Form CMS-2 Worksheet D-1	
			From 10/01/2020 To 09/30/2021		pared:
		Title XIX	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed	days, excluding newborn)		3, 286	1.00
2.00 3.00	Inpatient days (including private room days, excluding swi Private room days (excluding swing-bed and observation be	ing-bed and newborn days)	orivate room days,	1, 629 0	
4 00	do not complete this line.			702	1.00
4.00 5.00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private reporting period		er 31 of the cost	783 0	4.00 5.00
6. 00	Total swing-bed SNF type inpatient days (including privat reporting period (if calendar year, enter 0 on this line)	e room days) after December	31 of the cost	930	6.00
7.00	Total swing-bed NF type inpatient days (including private reporting period	room days) through Decembe	er 31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	room days) after December	31 of the cost	727	8.00
9.00	Total inpatient days including private room days applicable newborn days) (see instructions)	le to the Program (excludir	ig swing-bed and	10	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVI through December 31 of the cost reporting period (see ins	tructions)	5 /	0	10.00
	Swing-bed SNF type inpatient days applicable to title XVI December 31 of the cost reporting period (if calendar year	r, enter 0 on this line)	•	0	
	Swing-bed NF type inpatient days applicable to titles V or through December 31 of the cost reporting period	3 3 3 1	3 /	0	
	Swing-bed NF type inpatient days applicable to titles V or after December 31 of the cost reporting period (if calend	ar year, enter O on this li	ne)	0	
	Medically necessary private room days applicable to the Pr Total nursery days (title V or XIX only)	rogram (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to set	rvices through December 31	of the cost		17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to serve reporting period	rvices after December 31 of	the cost		18.00
19.00	Medicaid rate for swing-bed NF services applicable to service reporting period	vices through December 31 c	of the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	vices after December 31 of	the cost	0.00	20.00
	Total general inpatient routine service cost (see instruct			5, 646, 753	
	Swing-bed cost applicable to SNF type services through Der 5 x line 17)		0 1 1		22.00
	Swing-bed cost applicable to SNF type services after Decen x line 18)		0 1 1		
	Swing-bed cost applicable to NF type services through Deco 7 x line 19)			0	
	Swing-bed cost applicable to NF type services after Decemb x line 20)	ber 31 of the cost reportin	ig period (line 8	0	
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed co	ost (line 21 minus line 26)		2, 052, 157 3, 594, 596	
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing	g-bed and observation bed o	harges)	0	28.00
	Private room charges (excluding swing-bed charges)		and goo)	0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
	General inpatient routine service cost/charge ratio (line	27 ÷ line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 $\div$ line			0.00	
	Average per diem private room charge differential (line 32	, ,	icti ons)	0.00	
35.00	Average per diem private room cost differential (line 34 :			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 3			0	36.00
	General inpatient routine service cost net of swing-bed co 27 minus line 36)	ost and private room cost c	lifferential (line	3, 594, 596	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST			0.551	
	Adjusted general inpatient routine service cost per diem	. ,		2, 206. 62	
	Program general inpatient routine service cost (line 9 x			22, 066	
	Medically necessary private room cost applicable to the P			0	40.00
41.00	Total Program general inpatient routine service cost (line	e 39 + line 40)		22, 066	41.00

MPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1319	Peri od:	Worksheet D-	-2552 1
				From 10/01/2020 To 09/30/2021	Date/Time Pro	
					2/28/2022 10	
Cost Center Description	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
cost center bescription	Inpatient	Inpatient	Diem (col. 1		(col. 3 x	
	Cost	Days	÷ col . 2)		col. 4)	
	1.00	2.00	3.00	4.00	5.00	
00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Uni	+c					42
00 INTENSIVE CARE UNIT	243, 982	21	11, 618. 1	9 0	(	0 43
OO CORONARY CARE UNIT						44
OO BURN INTENSIVE CARE UNIT						45
00 SURGI CAL I NTENSI VE CARE UNI T						46
00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
cost center bescription					1.00	
00 Program inpatient ancillary service cost (	Wkst. D-3, col.	3, line 200)	-		17, 001	1 48
00 Total Program inpatient costs (sum of line	s 41 through 48)	(see instructi	ons)		39, 06	7 49
PASS THROUGH COST ADJUSTMENTS				n ef Dente I en		
00 Pass through costs applicable to Program i	npatient routine	services (Tro	m WKST. D, SU	m of Parts I and	(	0 50
00 Pass through costs applicable to Program in	npatient ancilla	rv services (f	rom Wkst. D.	sum of Parts II	(	0 51
and IV)	,	J			·	-
00 Total Program excludable cost (sum of line						0 52
00 Total Program inpatient operating cost exc		elated, non-ph	ysician anest	hetist, and	(	0 53
medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	le 52)					-
00 Program di scharges					(	0 54
00 Target amount per discharge					0.00	
00 Target amount (line 54 x line 55)						0 56
00 Difference between adjusted inpatient oper-	ating cost and ta	arget amount (	line 56 minus	line 53)		0 57
00 Bonus payment (see instructions)	concerting partial	anding 100(	undoted and a	ampaunded by the		0 58 0 59
00 Lesser of lines 53/54 or 55 from the cost market basket	reporting period	ending 1996,	updated and c	unpounded by the	0.00	0 59
00 Lesser of lines 53/54 or 55 from prior yea	r cost report, u	pdated by the	market basket		0.00	0 60
00 If line 53/54 is less than the lower of li					(	0 61
which operating costs (line 53) are less t		ts (lines 54 x	60), or 1% o	f the target		
amount (line 56), otherwise enter zero (see 00 Relief payment (see instructions)	e instructions)				(	0 62
<ul><li>00 Relief payment (see instructions)</li><li>00 Allowable Inpatient cost plus incentive pair</li></ul>	vment (see instru	uctions)				0 63
PROGRAM INPATIENT ROUTINE SWING BED COST						
00 Medicare swing-bed SNF inpatient routine c	osts through Dece	ember 31 of th	e cost report	ing period (See	(	0 64
instructions)(title XVIII only)						
00 Medicare swing-bed SNF inpatient routine continuations) (title XVIII only)	osts after Decemi	ber 31 of the	cost reportin	g period (See	(	0 65
00 Total Medicare swing-bed SNF inpatient rou	tine costs (line	64 plus line	65)(title XVI	ll only) For	(	0 66
CAH (see instructions)		or prao rino		, , , , , , , , , , , , , , , , , , ,	·	
00 Title V or XIX swing-bed NF inpatient rout	ine costs through	h December 31	of the cost r	eporting period	(	0 67
(line 12 x line 19)						
00 Title V or XIX swing-bed NF inpatient rout (line 13 x line 20)	ine costs after l	December 31 of	the cost rep	orting period	(	0 68
00 Total title V or XIX swing-bed NF inpatien	t routine costs	(line 67 + lin	e 68)		(	0 69
PART III - SKILLED NURSING FACILITY, OTHER		· · · · · · · · · · · · · · · · · · ·	/			
00 Skilled nursing facility/other nursing fac				)		70
00 Adjusted general inpatient routine service		line 70 ÷ line	2)			71
00 Program routine service cost (line 9 x line 00 Medically necessary private room cost appl		m (lin≏ 14 v I	ine 35)			72
00 Total Program general inpatient routine se						74
00 Capital -related cost allocated to inpatien	•		<i>,</i>	Part II, column		75
26, line 45)		, in the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s				
00 Per diem capital related costs (line 75 ÷	,					76
00 Program capital-related costs (line 9 x li 00 Inpatient routine service cost (line 74 mi						77
00 Aggregate charges to beneficiaries for exc	,	provider recor	ds)			79
00 Total Program routine service costs for co				nus line 79)		80
00 Inpatient routine service cost per diem lin				-		81
00 Inpatient routine service cost limitation	•					82
00 Reasonable inpatient routine service costs		ns)				83
00 Program inpatient ancillary services (see 00 Utilization review - physician compensation		ons)				84
00 Total Program inpatient operating costs (s						86
PART IV - COMPUTATION OF OBSERVATION BED P						
	20)				846	6 87
00 Total observation bed days (see instruction 00 Adjusted general inpatient routine cost pe					2, 206. 63	

Health Financial Systems	DEACONESS	GI BSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 10/01/2020	Worksheet D-1	
				To 09/30/2021	Date/Time Pre 2/28/2022 10:	pared: 06 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	508, 792	5, 646, 753	0.09010	3 1, 866, 809	168, 205	90.00
91.00 Nursing Program cost	0	5, 646, 753	0.00000	0 1, 866, 809	0	91.00
92.00 Allied health cost	0	5, 646, 753	0.00000	0 1, 866, 809	0	92.00
93.00 All other Medical Education	0	5, 646, 753	0.00000	1, 866, 809	0	93.00

Health Financial Systems DEACO	NESS GIBSON		In Lie	u of Form CMS-2	2552-10
I NPATI ENT ANCI LLARY SERVICE COST APPORTI ONMENT	Provider C		Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Pre 2/28/2022 10:	pared:
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			289, 485		30.00
31.00 03100 INTENSIVE CARE UNIT			16, 424		31.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 3990		4, 414	
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 1702		11, 554	54.00
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 3566		0	54.03
60. 00 06000 LABORATORY		0. 3129		45, 725	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2506		3, 440	
65. 00 06500 RESPI RATORY THERAPY		0. 3368			65.00
66. 00 06600 PHYSI CAL THERAPY		0. 3123		17, 641	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0.0000		0	67.00
68.00 06800 SPEECH PATHOLOGY		0.0000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.0000		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1.0826		64, 260	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4052		30	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4154			73.00
76.00 03480 I NFUSI ON THERAPY		0. 6058	33 636	385	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.0000		0	88.00
88.01 08801 RURAL HEALTH CLINIC II		0.0000		0	88.01
90. 00 09000 CLINIC		0. 3411		0	90.00
90. 01 09001 DI ABETES		0. 2003		0	90.01
90. 02 09002 OP PSYCH		0.0000		0	90.02
90. 03 09003 PALN MANAGEMENT		2.3572		0	90.03
91. 00 09100 EMERGENCY		0. 6316	11 18, 658	11, 785	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 6208			
200.00 Total (sum of lines 50 through 94 and 96 through			771, 552		
201.00 Less PBP Clinic Laboratory Services-Program only	charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			771, 552		202.00

Health Financial Systems DEACON	IESS GI BSON		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
			From 10/01/2020		
	Component	CCN: 15-Z319	To 09/30/2021	Date/Time Pre 2/28/2022 10:	
	Title	xviii	Swing Beds - SNF		
Cost Center Description		Ratio of Cos		I npati ent	
·		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
ANCI LLARY SERVI CE COST CENTERS		0.0000			50.00
50. 00 OSOOO OPERATING ROOM		0. 39903		-	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17025			
54. 03 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C		0. 35663		-	54.03
		0. 31293			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2506			
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0. 33681			65.00 66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 00000		229,011	67.00
68. 00 06800 SPEECH PATHOLOGY		0.00000			68.00
69. 00 06900 ELECTROCARDI OLOGY		0.00000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 08268		-	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 40526			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 41546			73.00
76. 00 03480 I NFUSI ON THERAPY		0. 60583			76.00
OUTPATIENT SERVICE COST CENTERS				-	
88.00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
88.01 08801 RURAL HEALTH CLINIC II		0.0000	00	0	88.01
90. 00 09000 CLINIC		0. 34116	04 0	0	90.00
90. 01 09001 DI ABETES		0. 20039	95 0	0	90.01
90. 02 09002 OP PSYCH		0. 00000	0 0	0	90.02
90. 03 09003 PALN MANAGEMENT		2. 35724	15 0	0	90.03
91. 00 09100 EMERGENCY		0. 6316	1 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 62088	4, 680		
200.00 Total (sum of lines 50 through 94 and 96 through 9			1, 387, 770	548, 476	
201.00 Less PBP Clinic Laboratory Services-Program only o	charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			1, 387, 770		202.00

Health Financial Systems DEACONESS (	GI BSON		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Pre 2/28/2022 10:	pared:
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			-		
30. 00 03000 ADULTS & PEDI ATRI CS			14, 797		30.00
31. 00 03100 I NTENSI VE CARE UNI T			1, 874		31.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 3990	33 6, 465	2, 580	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1702	50 7, 988	1, 360	54.00
54. 03 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C		0. 3566	37 611	218	54.03
60. 00 06000 LABORATORY		0. 3129	37 17, 870	5, 592	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2506	11 340	85	62.00
65. 00 06500 RESPI RATORY THERAPY		0. 3368	11 7, 955	2, 679	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 3123	32 528	165	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0.0000	0 00	0	67.00
68.00 06800 SPEECH PATHOLOGY		0.0000	0 00	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.0000	0 00	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 0826	39 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4052		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4154	55 0	0	73.00
76.00 03480 INFUSION THERAPY		0. 6058	33 0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		1. 2865	90 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II		0. 9376	39 0	0	88.01
90. 00 09000 CLINIC		0. 3411	64 0	0	90.00
90. 01 09001 DI ABETES		0. 2003	95 0	0	90.01
90. 02 09002 OP PSYCH		0.0000	0 00	0	90.02
90. 03 09003 PALN MANAGEMENT		2.3572	45 0	0	90.03
91. 00 09100 EMERGENCY		0. 6316	6, 843	4, 322	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1, 6208	31 0	0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			48, 600	17,001	
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)	(		48, 600		202.00
		1	,,		

Health Financial Systems DEACONESS G	GIBSON	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1319	Period: From 10/01/2020 To 09/30/2021	Date/Time Pre	
	Title XVIII	Hospi tal	2/28/2022 10: Cost	<u>06 am</u>
			1.00	
PART B - MEDI CAL AND OTHER HEALTH SERVI CES				
<ol> <li>Medical and other services (see instructions)</li> <li>Medical and other services reimbursed under OPPS (see instru-</li> </ol>	ictions)		6, 895, 513 0	
3.00 OPPS payments	ictions)		0	
4.00 Outlier payment (see instructions)			0	
<ul> <li>4.01 [Outlier reconciliation amount (see instructions)</li> <li>5.00 Enter the hospital specific payment to cost ratio (see instruction)</li> </ul>	uctions)		0.000	
6.00 Line 2 times line 5			0.000	1
7.00 Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
<ul> <li>8.00 Transitional corridor payment (see instructions)</li> <li>9.00 Ancillary service other pass through costs from Wkst. D, Pt.</li> </ul>	IV col 13 line 200		0	
10.00 Organ acquisitions	IV, COL. 15, THE 200		0	
11.00 Total cost (sum of lines 1 and 10) (see instructions)			6, 895, 513	11.00
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				-
12.00 Ancillary service charges			0	12.00
13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)		0	
14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14.00
15.00 Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.00
16.00 Amounts that would have been realized from patients liable for	or payment for services		0	16.00
had such payment been made in accordance with 42 CFR §413.13 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000)	8(e)		0. 000000	17.00
18.00 Total customary charges (see instructions)			0.000000	
19.00 Excess of customary charges over reasonable cost (complete or	only if line 18 exceeds l	ine 11) (see	0	19.00
instructions) 20.00 Excess of reasonable cost over customary charges (complete o	nlvifline 11 exceeds l	ine 18) (see	0	20.00
i nstructi ons)				20.00
21.00 Lesser of cost or charges (see instructions)			6, 964, 468	
<ul><li>22.00 Interns and residents (see instructions)</li><li>23.00 Cost of physicians' services in a teaching hospital (see inst</li></ul>	structions)		0	
24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	1
COMPUTATION OF REIMBURSEMENT SETTLEMENT			24 517	25.00
25.00 Deductibles and coinsurance amounts (for CAH, see instruction 26.00 Deductibles and Coinsurance amounts relating to amount on lin		ructions)	36, 517 3, 056, 695	
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			3, 871, 256	27.00
instructions) 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	1
30.00 Subtotal (sum of lines 27 through 29)			3, 871, 256	
31.00 Primary payer payments 32.00 Subtotal (line 30 minus line 31)			1, 406 3, 869, 850	
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	(I CES)		0,007,000	02.00
33.00 Composite rate ESRD (from Wkst. I-5, line 11)			0	
<ul><li>34.00 Allowable bad debts (see instructions)</li><li>35.00 Adjusted reimbursable bad debts (see instructions)</li></ul>			248, 158 161, 303	
36.00 Allowable bad debts for dual eligible beneficiaries (see ins	structions)		242, 885	
37.00 Subtotal (see instructions)			4, 031, 153	
38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39.50 Pioneer ACO demonstration payment adjustment (see instruction	ons)			39.50
39.97 Demonstration payment adjustment amount before sequestration		-+!>	0	
39.98 Partial or full credits received from manufacturers for repl 39.99 RECOVERY OF ACCELERATED DEPRECIATION	aced devices (see instru	ctrons)	0	
40.00 Subtotal (see instructions)			4, 031, 153	
40.01 Sequestration adjustment (see instructions)			0	
40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs			0	40.02
41.00 Interim payments			5, 227, 345	
41.01 Interim payments-PARHM				41.01
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only)			0	42.00
43. 00 Balance due provider/program (see instructions)			-1, 196, 192	1
43.01 Balance due provider/program-PARHM (see instructions)	lance with CNS Dub 15 2	chaptor 1		43.01
44.00 Protested amounts (nonallowable cost report items) in accorda §115.2	ance with two Pub. 15-2,	chapter I,	0	44.00
TO BE COMPLETED BY CONTRACTOR			-	00.0-
<ul><li>90.00 Original outlier amount (see instructions)</li><li>91.00 Outlier reconciliation adjustment amount (see instructions)</li></ul>			0	
92.00 The rate used to calculate the Time Value of Money			0.00	92.00
			0. 00 0	

	n Financial Systems DEACONESS SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-1319	Period:	Worksheet E-1	
				From 10/01/2020 To 09/30/2021		nareo
					2/28/2022 10:	06 an
			XVIII	Hospi tal	Cost	
		Inpatien	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		680, 96		5, 227, 345	1.(
. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2.0
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
. 00	List separately each retroactive lump sum adjustment					3.0
	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					
. 01	ADJUSTMENTS TO PROVI DER	07/29/2021	299, 20		0	3.0
. 02				0	0	3.
. 03				0	0	3.
. 04 . 05				0	0	3. 3.
. 05	Provider to Program				0	5.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53 54				0	0	3. 3.
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		299, 20	-	0	3.
	3. 50-3. 98)		277720		, i i i i i i i i i i i i i i i i i i i	
00	Total interim payments (sum of lines 1, 2, and 3.99)		980, 1 <i>6</i>	65	5, 227, 345	4.
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) 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)					
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5
02				0	0	5.
03				0	0	5.
	Provider to Program	1		-		
50	TENTATI VE TO PROGRAM			0	0	5.
51 52				0	0	5. 5.
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5.
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6.
01	the cost report. (1) SETTLEMENT TO PROVIDER		7,78	20	0	6.
01	SETTLEMENT TO PROVIDER		1, 78	0	1, 196, 192	6.
00	Total Medicare program liability (see instructions)		987, 95		4, 031, 153	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1.00	2.00	

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C	CN: 15-1319 CCN: 15-Z319	Period: From 10/01/2020 To 09/30/2021		pared
		Title	XVIII	Swing Beds - SN	F Cost	
		Inpati en	t Part A	Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 2. 00 3. 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, 737, 4	27 0	000	
	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					
8. 01	ADJUSTMENTS TO PROVIDER	07/29/2021	378, 2		0	
6. 02 6. 03				0	0	
. 03 . 04				0	0	
. 05				0	0	3.0
	Provider to Program				1	
. 50	ADJUSTMENTS TO PROGRAM			0	0	
. 51 . 52				0	0	
. 53				0	0	
. 54				0	0	3.5
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		378, 2		0	
. 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)		2, 115, 6	27	0	4.(
	TO BE COMPLETED BY CONTRACTOR				1	
. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.0
	Program to Provider					1
. 01 . 02	TENTATI VE TO PROVIDER			0	0	
. 03				0	0	
	Provider to Program			•		
. 50	TENTATI VE TO PROGRAM			0	0	
. 51 . 52				0	0	
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
01	SETTLEMENT TO PROVIDER		432, 2	51	0	
02	SETTLEMENT TO PROGRAM		2 547 0	0	0	
00	Total Medicare program liability (see instructions)		2, 547, 8	Contractor	NPR Date	7.
				Number	(Mo/Day/Yr)	
		C	)	1.00	2.00	

Heal th	Financial Systems DEACONE	ESS GIBSON	In Lie	u of Form CMS	-2552-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1319	Period: From 10/01/2020	Worksheet E Part II	-1		
			To 09/30/2021	Date/Time Pr 2/28/2022 10			
		Title XVIII	Hospi tal	Cost			
				1.00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPOR						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCUL				1.00		
1.00							
2.00	5						
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 line	5			4.00		
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 2	.00			5.00		
6.00	Total hospital charity care charges from Wkst. S-10, col	. 3 line 20			6.00		
7.00	CAH only - The reasonable cost incurred for the purchase line 168	of certified HIT technology	Wkst. S-2, Pt. I		7.00		
8.00	Calculation of the HIT incentive payment (see instructio	ins)			8.00		
9.00	Sequestration adjustment amount (see instructions)				9.00		
10.00	Calculation of the HIT incentive payment after sequestra	tion (see instructions)			10.00		
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH						
30.00	Initial/interim HIT payment adjustment (see instructions	.)			30.00		
	Other Adjustment (specify)				31.00		
32.00	Balance due provider (line 8 (or line 10) minus line 30	and line 31) (see instructio	ns)		32.00		

ALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	SON Provider CCN: 15-1319	Peri od:	u of Form CMS-2 Worksheet E-2	
	Component CCN: 15-Z319	From 10/01/2020 To 09/30/2021	Date/Time Pre 2/28/2022 10:	pared 06 am
	Title XVIII	Swing Beds - SNF	Cost	
		Part A 1.00	<u>Part B</u> 2.00	
COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
00 Inpatient routine services - swing bed-SNF (see instructions)		2, 014, 789	0	1.0
00 Inpatient routine services - swing bed-NF (see instructions)				2.0
00 Ancillary services (from Wkst. D-3, col. 3, line 200, for Part			0	3.0
Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swin instructions)	g-bed pass-through, see	9		
01 Nursing and allied health payment-PARHM (see instructions)				3.0
00 Per diem cost for interns and residents not in approved teachi	ng program (see		0.00	
instructions)				
00 Program days		930	0	
00 Interns and residents not in approved teaching program (see in 00 Utilization review - physician compensation - SNF optional met		0	0	6.0
00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	iou oni y	2, 568, 750	0	
00 Primary payer payments (see instructions)		0	0	
). 00 Subtotal (line 8 minus line 9)		2, 568, 750	0	10.0
I.00 Deductibles billed to program patients (exclude amounts applic	able to physician	0	0	11.0
professional services)		2 549 750	0	12.0
2.00  Subtotal (line 10 minus line 11) 3.00  Coinsurance billed to program patients (from provider records)	(exclude coinsurance	2, 568, 750 20, 872	0	
for physician professional services)		20,072	0	15.0
4.00 80% of Part B costs (line 12 x 80%)			0	
5.00 Subtotal (see instructions)		2, 547, 878	0	15.0
5. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
5.50 Pioneer ACO demonstration payment adjustment (see instructions		0		16.5
6.55 Rural community hospital demonstration project (§410A Demonstr adjustment (see instructions)	atron) payment	0		16.5
5. 99 Demonstration payment adjustment amount before sequestration		0	0	16.9
7.00 Allowable bad debts (see instructions)		0	0	17.0
7.01 Adjusted reimbursable bad debts (see instructions)		0	0	
3.00 Allowable bad debts for dual eligible beneficiaries (see instr	uctions)	0	0	
2.00 Total (see instructions)		2, 547, 878	0	
<ul> <li>9.01 Sequestration adjustment (see instructions)</li> <li>9.02 Demonstration payment adjustment amount after sequestration)</li> </ul>		0	0	
9.03 Sequestration adjustment-PARHM pass-throughs		0	0	19.0
9.25 Sequestration for non-claims based amounts (see instructions)		0	0	19.2
0.00 Interim payments		2, 115, 627	0	
0.01 Interim payments-PARHM				20.0
I.OO  Tentative settlement (for contractor use only) I.O1  Tentative settlement-PARHM (for contractor use only)		0	0	21.0 21.0
2.00 Balance due provider/program (line 19 minus lines 19.01, 19.02	19 25 20 and 21)	432, 251	0	
2. 01 Balance due provider/program-PARHM (see instructions)	·// 20, 20, and 21)	102/201		22.0
3.00 Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2,	0	0	23.0
chapter 1, §115.2				
<u>Rural Community Hospital Demonstration Project (§410A Demonstration</u> 00.00 Is this the first year of the current 5-year demonstration per				200 0
Century Cures Act? Enter "Y" for yes or "N" for no.				200. 0
Cost Reimbursement				
01.00 Medicare swing-bed SNF inpatient routine service costs (from W	kst. D-1, Pt. II, line			201.0
66 (title XVIII hospital))				
D2.00 Medicare swing-bed SNF inpatient ancillary service costs (from 200 (title XVIII swing-bed SNF))	WKST. D-3, COL. 3, III	ne		202. C
03.00 Total (sum of lines 201 and 202)				203.0
04.00 Medicare swing-bed SNF discharges (see instructions)				204.0
Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	ent 5-year demons		1
period)				0.0-
)5.00 Medicare swing-bed SNF target amount )6.00 Medicare swing bed SNE inpatient routine cost can (Line 205 ti	nos lipo 204)			205. 0 206. 0
06.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 ti Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs)				200.0
07.00 Program reimbursement under the §410A Demonstration (see instr				207.0
08.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	-	1		208.0
and 3)				
09.00 Adjustment to Medicare swing-bed SNF PPS payments (see instruc	tions)			209.0
10.00 Reserved for future use				210. 0
Comparision of PPS versus Cost Reimbursement 15.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 2	)9 nlus line 210) (see			215.0
instructions)				

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1319	Period:	Worksheet E-3	
			From 10/01/2020 To 09/30/2021	Part V Date/Time Pre	
		Title XVIII	Hospi tal	2/28/2022 10: Cost	06
			nospitai	0031	
	DADT V CALCULATION OF DELUDURGENENT CETTLENENT FOR M			1.00	-
00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR M Inpatient services	EDICARE PARI A SERVICES - COS	I REIMBURSEMENT	1 002 257	1.
00	Nursing and Allied Health Managed Care payment (see in	etructions)		1, 092, 357 0	
00	Organ acqui si ti on	istructrons)		0	
00	Subtotal (sum of lines 1 through 3)			1, 092, 357	
00	Primary payer payments			1, 072, 007	
00	Total cost (line 4 less line 5). For CAH (see instruct	i ons)		1, 103, 281	
00	COMPUTATION OF LESSER OF COST OR CHARGES			17 1007 201	
	Reasonabl e charges				1
00	Routi ne servi ce charges			0	
. 00	Ancillary service charges			0	
. 00	Organ acquisition charges, net of revenue			0	
0. 00	Total reasonable charges			0	1
	Customary charges				
1.00	Aggregate amount actually collected from patients liab	1 5	5	0	
2.00	Amounts that would have been realized from patients li		on a charge basis	0	1
	had such payment been made in accordance with 42 CFR 4	13.13(e)			
3.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	
	Total customary charges (see instructions)			0	1
5.00	Excess of customary charges over reasonable cost (comp	olete only if line 14 exceeds l	ine 6) (see	0	1
4 00	instructions) Excess of reasonable cost over customary charges (comp	lata anly if line ( avagada li	no. 14) (coo	0	1
6.00	instructions)	field only if the blexceeds if	The T4) (See	0	1
7.00	Cost of physicians' services in a teaching hospital (s	see instructions)		0	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		1		1
8.00	Direct graduate medical education payments (from Works	heet E-4, line 49)		0	1
9.00	Cost of covered services (sum of lines 6, 17 and 18)			1, 103, 281	1
0. 00	Deductibles (exclude professional component)			113, 472	2
1.00	Excess reasonable cost (from line 16)			0	2
2.00	Subtotal (line 19 minus line 20 and 21)			989, 809	2
3.00	Coinsurance			1, 855	2
4.00	Subtotal (line 22 minus line 23)			987, 954	
	Allowable bad debts (exclude bad debts for professiona	l services) (see instructions)		0	
6.00	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (s	see instructions)		0	1 -
8.00	Subtotal (sum of lines 24 and 25, or line 26)			987, 954	
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50	Pioneer ACO demonstration payment adjustment (see inst	ructions)		0	
9.98	Recovery of accel erated depreciation.			0	1 -
9.99	Demonstration payment adjustment amount before sequest	ration		0	
0.00	Subtotal (see instructions)			987, 954	
D. 01	Sequestration adjustment (see instructions)	ration		0	
). 02	Demonstration payment adjustment amount after sequestr Sequestration adjustment-PARHM	ation		0	3
1.00				980, 165	
1.00	Interim payments-PARHM			700, 100	3
2.00	Tentative settlement (for contractor use only)			0	
2.00	Tentative settlement PARHM (for contractor use only)			0	3
3.00	Balance due provider/program (line 30 minus lines 30.0	1 30 02 31 and 32)		7, 789	
3.00	Bal ance due provi der/program-PARHM (lines 2, 3, 18, an	· · · · · ·	and 32,01)	,,,07	3
4.00	Protested amounts (nonallowable cost report items) in			0	

		Describer CON 45 4010	Daval and		2552
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1319	Period: From 10/01/2020 To 09/30/2021		epare
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR	XIX SERVICES		-
00	COMPUTATION OF NET COST OF COVERED SERVICES		20.0/7		1 1
00 00	Inpatient hospital/SNF/NF services		39, 067	0	1
00	Medical and other services Organ acquisition (certified transplant centers only)		0	0	
00	Subtotal (sum of lines 1, 2 and 3)		39, 067	0	
00	Inpatient primary payer payments		0	Ū	5
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		39, 067	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
00	Routine service charges		16, 671		8
00	Ancillary service charges		48, 600	0	
). 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0	0	1
. 00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		65, 271	0	12
3.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	113
5.00	basis	services on a charge	0	0	
1.00	Amounts that would have been realized from patients liable for	payment for services	on 0	0	14
	a charge basis had such payment been made in accordance with 4				·
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	1
5.00	Total customary charges (see instructions)		65, 271	0	16
. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	26, 204	0	17
	line 4) (see instructions)				
3. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds li	ne 0	0	18
	16) (see instructions)			0	19
9.00 0.00	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see instr	suctions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line 1	-	39,067	0	
1.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	12
2.00	Other than outlier payments		0	0	22
	Outlier payments		0	0	
1.00	Program capital payments		0		24
6. 00	Capital exception payments (see instructions)		0		2
5.00	Routine and Ancillary service other pass through costs		0	0	
7.00	Subtotal (sum of lines 22 through 26)		0	0	
3.00	Customary charges (title V or XIX PPS covered services only)		0	0	
9.00	Titles V or XIX (sum of lines 21 and 27)		39, 067	0	29
~ ~~	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 20
	Excess of reasonable cost (from line 18)		0 39, 067	0	
1.00 2.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		39,007	0	
2.00 3.00	Coi nsurance		0	0	
I. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0	0	35
5.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	39,067	0	
7.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	0	0	
3.00	Subtotal (line 36 ± line 37)		39, 067	0	
9.00	Direct graduate medical education payments (from Wkst. E-4)		0		39
0. 00	Total amount payable to the provider (sum of lines 38 and 39)		39, 067	0	
1.00	Interim payments		43, 437	0	
	Balance due provider/program (line 40 minus line 41)		-4, 370	0	42
2.00 3.00	Protested amounts (nonallowable cost report items) in accordan		., ., .	0	43

	Financial Systems DEACONESS E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider CC	Fi Ti	eriod: com 10/01/2020 o 09/30/2021	u of Form CMS-2 Worksheet G Date/Time Pre 2/28/2022 10:	pared:
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
. 00	Cash on hand in banks Temporary investments	27, 749, 635 0	0000	0 0	0	1.00
. 00 . 00 . 00	Notes recei vabl e Accounts recei vabl e Other recei vabl e	0 5, 661, 751 607, 556	0 0 0	0 0 0	0 0 0	3.00 4.00 5.00
. 00 . 00 . 00	Allowances for uncollectible notes and accounts receivable Inventory Prepaid expenses	-3, 306, 681 487, 646 533, 640	0 0 0	0 0 0	0 0 0	6.00 7.00 8.00
. 00 0. 00	Other current assets Due from other funds Total current assets (sum of lines 1-10)	1, 418, 901 0 33, 152, 448	0 0	0 0 0	0 0 0	9.00 10.00 11.00
	FIXED ASSETS		-			
	Land Land improvements	421, 244 7, 337, 196	0	0	0	12.00 13.00
	Accumulated depreciation	-45	0	0	0	14.00
	Bui I di ngs	1,700	0	0	0	15.00
	Accumulated depreciation Leasehold improvements	-565, 191 0	0	0	0	16.00 17.00
	Accumulated depreciation	0	0	0	0	18.00
	Fixed equipment	8, 369, 933	0	0	0	19.00
	Accumulated depreciation Automobiles and trucks	-1, 502, 479 0	0	0	0	20.00
	Accumulated depreciation	0	0	0	0	22.00
	Major movable equipment	0	0	0	0	23.00
	Accumulated depreciation Minor equipment depreciable	0	0	0	0	24.0 25.0
	Accumulated depreciation	0	0	0	0	26.0
7.00	HIT designated Assets	0	0	0	0	27.00
	Accumulated depreciation	0	0	0	0	28.0
	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29) OTHER ASSETS	14, 062, 358	0	0	0	29.00 30.00
	Investments	2, 624, 085	0	0	0	31.00
	Deposits on leases Due from owners/officers	0	0	0	0	32.00 33.00
	Other assets	0	0	0	0	34.0
	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	2, 624, 085 49, 838, 891	0	0	0	35.0 36.0
	Accounts payable	1, 707, 360	0	0	0	37.00
	Salaries, wages, and fees payable	1, 613, 974	0	0	0	38.00 39.00
	Payroll taxes payable Notes and loans payable (short term)	0 -1, 486, 470	0	0	0	40.0
	Deferred income	0	0	0	0	41.0
	Accelerated payments Due to other funds	0	0	0	0	42.0 43.0
	Other current liabilities	12, 215, 197	0	0	0	43.0
	Total current liabilities (sum of lines 37 thru 44)	14, 050, 061	0	0	0	45.00
( 00	LONG TERM LIABILITIES	0	0			
	Mortgage payable Notes payable	0 14, 610, 964	0	0	0	46.0 47.0
	Unsecured Loans	0	0	0	0	48.0
	Other long term liabilities	0	0	0	0	49.0
	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	14, 610, 964 28, 661, 025	0	0	0	50.0 51.0
1.00	CAPITAL ACCOUNTS	28,001,023	0	0	0	51.0
	General fund balance	21, 177, 866				52.0
	Specific purpose fund Donor created - endowment fund balance - restricted		0	0		53.00 54.00
	Donor created - endowment fund balance - restricted			0		55.00
6.00	Governing body created - endowment fund balance			0		56.0
	Plant fund balance - invested in plant				0	57.0
8.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.0
9.00	Total fund balances (sum of lines 52 thru 58)	21, 177, 866	0	О	0	59.0
0.00	Total liabilities and fund balances (sum of lines 51 and	49, 838, 891	0	o	0	60.0

Heal th	Financial Systems	DEACONESS	GI BSON			In Lie	u of Form CM	S-2	552-10
STATEN	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1319		riod: om 10/01/2020 09/30/2021	Worksheet ( Date/Time F 2/28/2022	Prep	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund		
		1.00	2.00	3.00		4.00	5.00	+	
$\begin{array}{c} \hline 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ \end{array}$	<ul> <li>2.00 Net income (loss) (from Wkst. G-3, line 29)</li> <li>3.00 Total (sum of line 1 and line 2)</li> <li>4.00 Additions (credit adjustments) (specify)</li> <li>5.00</li> <li>5.00</li> <li>5.00</li> <li>7.00</li> <li>3.00</li> <li>7.00</li> <li>10.00 Total additions (sum of line 4-9)</li> <li>11.00 Subtotal (line 3 plus line 10)</li> <li>12.00 Deductions (debit adjustments) (specify)</li> <li>13.00</li> <li>14.00</li> <li>15.00</li> <li>16.00</li> <li>17.00</li> <li>17.00</li> <li>18.00 Total deductions (sum of lines 12-17)</li> </ul>		21, 849, 975 9, 327, 891 21, 177, 866 0 21, 177, 866 0 21, 177, 866	3.00	0 0 0 0 0 0 0 0 0 0 0	4.00 0 0 0 0 0 0 0 0 0	3.00	0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ \end{array}$
		Endowment Fund	PI ant	Fund					
1.00		6.00	7.00	8.00					1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0				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	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0 0	0 0 0 0 0 0		0 0				9.00         10.00         11.00         12.00         13.00         14.00         15.00         16.00         17.00         18.00
	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0				19.00

STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-1319	Peri od:	Worksheet G-2	2552-1 !
				From 10/01/2020 To 09/30/2021		
	Cost Center Description		Inpatient	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES		-			
	General Inpatient Routine Services					
1.00	Hospi tal		4, 048, 54	43	4, 048, 543	1.0
2.00	SUBPROVIDER - IPF					2.0
3.00	SUBPROVIDER - IRF					3.0
4.00	SUBPROVIDER					4.0
5.00	Swing bed - SNF			0	0	5.0
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY					7.0
8.00	NURSING FACILITY					8.0
9.00	OTHER LONG TERM CARE		1 040 5	10	4 040 542	9.0
10.00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services		4, 048, 54	+3	4, 048, 543	10.0
11.00	INTENSIVE CARE UNIT		26, 68	30	26, 689	111.0
12.00	CORONARY CARE UNIT		20,00	57	20,007	12.0
13.00	BURN I NTENSI VE CARE UNI T					13.0
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.0
15.00	OTHER SPECIAL CARE (SPECIFY)					15.0
16.00	Total intensive care type inpatient hospital services (sum of 11-15)	lines	26, 68	39	26, 689	
17.00	Total inpatient routine care services (sum of lines 10 and 16	)	4, 075, 23	32	4, 075, 232	17.0
18.00	Ancillary services	·	3, 572, 60			
19.00	Outpatient services		268, 99			
20.00	RURAL HEALTH CLINIC			0 744, 946	744, 946	20.0
20. 01	RURAL HEALTH CLINIC II			0 1, 777, 128	1, 777, 128	20.0
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.0
22.00	HOME HEALTH AGENCY			920, 372	920, 372	22.0
23.00	AMBULANCE SERVICES					23.0
24.00	СМНС					24.0
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.0
26.00	HOSPICE					26.0
27.00	PRO FEES			0 1, 115, 394		
27.01	PROFESSIONAL	1	7 01/ 0/	0 4, 630, 464		
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 G-3, line 1) PART II - OPERATING EXPENSES	to wkst.	7, 916, 83	77, 879, 840	85, 796, 674	28.0
29.00	Operating expenses (per Wkst. A, column 3, line 200)		1	38, 792, 753		29.0
30.00	ADD (SPECIFY)			0		30.0
31.00				0		31.0
32.00				0		32.0
33.00				0		33.0
34.00				0		34.0
35.00			1	0		35.0
36.00	Total additions (sum of lines 30-35)			C		36.0
37.00	DEDUCT (SPECIFY)			0		37.0
38.00				0		38.0
39.00				0		39.0
40.00				0		40.0
41.00				0		41.0
42.00	Total deductions (sum of lines 37-41)			C		42.0
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer	·	38, 792, 753		43.0

Heal th	Financial Systems DEA	ACONESS GI BSON	In Lie	u of Form CMS-2	2552-10
STATEM	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-1319	Period: From 10/01/2020 To 09/30/2021	Worksheet G-3 Date/Time Pre 2/28/2022 10:	pared:
				1.00	
1 00	Tatal actions groups (from West C. 2. Dout L. acti			1.00	1 00
1.00 2.00	Total patient revenues (from Wkst. G-2, Part I, colu			85, 796, 674 40, 341, 906	1.00 2.00
2.00	Less contractual allowances and discounts on patient Net patient revenues (line 1 minus line 2)	is accounts		40, 341, 908	2.00
3.00 4.00	Less total operating expenses (from Wkst. G-2, Part	II line (2)		38, 792, 753	
5.00	Net income from service to patients (line 3 minus li			6, 662, 015	
5.00	OTHER I NCOME			0,002,013	5.00
6.00	Contributions, donations, bequests, etc			116, 077	6.00
7.00	Income from investments			74, 317	
8.00	Revenues from telephone and other miscellaneous comm	nunication services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			116, 536	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies t	o other than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	
18.00	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20.00	Revenue from gifts, flowers, coffee shops, and cante	een		0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			93, 877	
23.00	Governmental appropriations			0	23.00
24.00	OTHER OPERATING INCOME			15, 481	
24.50	COVI D-19 PHE Fundi ng			2, 249, 588	
25.00	Total other income (sum of lines 6-24)			2, 665, 876	
26.00	Total (line 5 plus line 25)			9, 327, 891	
	OTHER EXPENSES (SPECIFY) Total other expenses (sum of line 27 and subscripts)			0	27.00 28.00
	Net income (or loss) for the period (line 26 minus l			9, 327, 891	
29.00	Iner income (or ross) for the period (rifle 20 millios r	1110 20)		9, 327, 891	∠9.00

Heal th	Financial Systems		DEACONESS	GI BSON		In Lie	u of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED HOME HEALT	TH AGENCY COSTS	;	Provider CO	CN: 15-1319	Period: From 10/01/2020	Worksheet H	
				HHA CCN:	15-7445	To 09/30/2021		pared:
						Home Health	2/28/2022 10: PPS	
		Calarian	Envel av a a	Transmentation	Counting attack (D	Agency I	Tatal (avm of	
		Sal ari es	Employee Benefits	Transportatio n (see	rchased	u Other Costs	Total (sum of cols. 1 thru	
		1.00		instructions)	Servi ces		5)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Capital Related - Bldg. &			0		0	0	1.00
2.00	Fixtures Capital Related - Movable			0		0	0	2.00
	Equi pment			0				
3.00 4.00	Plant Operation & Maintenance Transportation	0	0	0		0 0	0	3.00 4.00
5.00	Administrative and General	85, 871	7, 549	0		0 94, 574	187, 994	
( 00	HHA REIMBURSABLE SERVICES	100 700	11 754	0		0 215 442	240,000	
6.00 7.00	Skilled Nursing Care Physical Therapy	133, 703 116, 857	11, 754 10, 273	0		0 215, 442 0 0	360, 899 127, 130	
8.00	Occupational Therapy	72, 944	6, 413	0		0 0	79, 357	8.00
9. 00 10. 00	Speech Pathology Medical Social Services	11, 175 22	982	0		0 0	12, 157 25	1
11.00	Home Heal th Ai de	32, 461	2, 854	0		0 0	35, 315	11.00
12.00 13.00	Supplies (see instructions) Drugs	0	0	0		0 0 0 601	0 601	
14.00	DME	0		0		0 0	0	
15 00	HHA NONREI MBURSABLE SERVI CES		0					15 00
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	-	0		0 0 0 0	0	
17.00	Private Duty Nursing	0	0	0		0 0	0	17.00
18.00 19.00	Clinic Health Promotion Activities	0	0	0			0	18.00 19.00
20.00		0	0	0		0 0	0	20.00
21.00 22.00	Home Delivered Meals Program Homemaker Service	0	0	0		0 0	0	21.00 22.00
22.00	All Others (specify)	0	0	0		0 0	0	
23.50	Tel emedi ci ne	0	0	0		0 0	0	
24.00	Total (sum of lines 1-23)	453, 033 Recl assi fi cat		Adjustments	Net Expenses	0 310, 617	803, 478	24.00
		i on	Trial Balance	5	for			
			(col. 6 + col.7)		Allocation (col. 8 +			
		7.00		0.00	col . 9)	_		-
	GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00			
1.00	Capital Related - Bldg. &	0	0	0		0		1.00
2.00	Fixtures Capital Related - Movable	0	0	0		0		2.00
	Equi pment		0	0				
3.00 4.00	Plant Operation & Maintenance Transportation	0	0	0		0		3.00 4.00
5.00	Administrative and General	-182	-	0	187, 81	2		5.00
6.00	HHA REIMBURSABLE SERVICES	0	360, 899	0	360, 89			6.00
7.00	Skilled Nursing Care Physical Therapy	0		0	127, 13			7.00
8.00	Occupational Therapy	0	79, 357	0	79, 35			8.00
9. 00 10. 00	Speech Pathology Medical Social Services	0	12, 157 25	0	12, 15	25		9.00 10.00
11.00	Home Health Aide	0	35, 315	0	35, 31			11.00
12.00 13.00	Supplies (see instructions) Drugs	0 -600	0	0		0		12.00 13.00
14.00	0	000		0		0		14.00
15 00	HHA NONREI MBURSABLE SERVI CES		0	0				15 00
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0		0 0		0		15.00 16.00
17.00	Private Duty Nursing	0	0	0		0		17.00
18.00 19.00	Clinic Health Promotion Activities		0	0		0		18.00 19.00
20.00	Day Care Program	0	0	0		Ō		20.00
	Home Delivered Meals Program Homemaker Service	0	0	0		0		21.00 22.00
23.00	All Others (specify)	0	0	0		ŏ		23.00
	Telemedicine Total (sum of lines 1–23)	0	-	0	802, 69	0		23.50 24.00
∠4. UU	TOTAL (SUIL OF LENES 1-23)	-782	802, 096	0	δUZ, 65			24.00

Heal th	Financial Systems		DEACONESS	GI BSON		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HHA GENERAL SERVICE	E COST		Provider C HHA CCN:	CN: 15-1319 15-7445	Period: From 10/01/2020 To 09/30/2021	Worksheet H-1 Part I Date/Time Pre 2/28/2022 10:	pared:
						Home Health	PPS	00 411
			Capital Rela	ated Costs		Agency I		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fi xtures	Movable Equipment	Plant Operation 8 Maintenance		Subtotal (col s. 0-4)	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	3.00	4.00	4A. 00	
1.00	Capital Related - Bldg. &	0	0				0	1.00
2.00	Fixtures Capital Related - Movable	0		0			0	2.00
	Equi pment	0		0			0	
3.00 4.00	Plant Operation & Maintenance Transportation	0	0	0		0 0	0	3.00 4.00
5.00	Administrative and General	187, 812	0	0		0 0	187, 812	
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	360, 899	0	0		0 0	360, 899	6.00
7.00	Physical Therapy	127, 130	0	0		0 0	127, 130	7.00
8.00 9.00	Occupational Therapy Speech Pathology	79, 357 12, 157	0	0		0 0	79, 357 12, 157	
9.00 10.00	Medical Social Services	25	0	0		0 0	25	
11.00	Home Heal th Ai de	35, 315	0	0		0 0		11.00
12.00 13.00	Supplies (see instructions) Drugs	0	0	0		0	0	12.00 13.00
14.00		0	0	0		0 0	0	14.00
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00	Respiratory Therapy	0	0	0		0 0	0	
17.00 18.00	Private Duty Nursing Clinic	0	0	0		0 0	0	
19.00	Health Promotion Activities	0	0	0		0 0	0	19.00
20.00 21.00	Day Care Program Home Delivered Meals Program	0	0	0		0 0	0	
22.00	Homemaker Service	0	0	0		0 0	0	
23.00 23.50	All Others (specify) Telemedicine	0	0	0		0 0 0 0	0	
	Total (sum of lines 1-23)	802, 696	0	0		0 0	802, 696	
		Administrativ e & General	Total (cols. 4A + 5)					
		5. 00	6. 00					
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	[]						1.00
	Fixtures							
2.00	Capital Related – Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00 5.00	Transportation Administrative and General	187, 812						4.00 5.00
	HHA REIMBURSABLE SERVICES							1
6.00 7.00	Skilled Nursing Care Physical Therapy	110, 234 38, 831	471, 133 165, 961					6.00 7.00
8.00	Occupational Therapy	24, 239	103, 596					8.00
9.00	Speech Pathology Medical Social Services	3, 713	15, 870					9.00
10.00 11.00	Home Health Aide	8 10, 787	33 46, 102					10.00
12.00	Supplies (see instructions)	0	0					12.00
13.00 14.00	Drugs DME	0	1					13.00 14.00
	HHA NONREI MBURSABLE SERVI CES		1					
15.00 16.00		0	0					15.00 16.00
17.00	Private Duty Nursing	0	О					17.00
18.00 19.00	Clinic Health Promotion Activities	0	0					18.00 19.00
20.00	Day Care Program	0	0					20.00
21.00 22.00	Home Delivered Meals Program Homemaker Service	0	0					21.00 22.00
23.00	All Others (specify)	0	0					23.00
	Telemedicine Total (sum of lines 1-23)	0	0 802, 696					23.50 24.00
27.00		1	002,070					1 2 7.00

Heal th	Financial Systems		DEACONESS	GLBSON		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HHA STATISTICAL BAS	SI S		Provider C	CN: 15-1319	Peri od:	Worksheet H-1	
				HHA CCN:	15-7445	From 10/01/2020 To 09/30/2021		
						Home Health	PPS	
		Capital Dal	atad Casta			Agency I		
		Capital Rel	aled Costs					
		BIdgs &	Movabl e	Plant	Transportati	o Reconciliatio	Administrativ	1
		Fixtures	Equi pment	Operation &	n (MILEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance			(ACCUM. COST)	
			VALUE)	(SQUARE FEET)				
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0				0		1.00
2 00	Fixtures		0					2 00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see	0	0	0		0		4.00
	instructions)	_	-	-				
5.00	Administrative and General	0	0	0		0 -187, 812	614, 884	5.00
	HHA REIMBURSABLE SERVICES							1
6.00	Skilled Nursing Care	0	0	0		0 0	360, 899	
7.00	Physical Therapy	0	0	-		0 0	,	•
8.00	Occupational Therapy	0	0	0		0 0	79, 357	•
9.00	Speech Pathology	0	0	0		0 0	12, 157	•
10.00	Medical Social Services	0	0	0		0 0	25	
11.00	Home Heal th Ai de	0	0	0				11.00
12.00 13.00	Supplies (see instructions)	0	0	0			0	12.00 13.00
13.00	Drugs DME	0	0	-		0 0		
14.00	HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14.00
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00	Respiratory Therapy	0	0	0		0 0	-	
17.00	Private Duty Nursing	0	0	0		0 0	0	17.00
18.00	Clinic	0	0	0		0 0	0	18.00
19.00	Health Promotion Activities	0	0	0		0 0	0	19.00
20.00	Day Care Program	0	0	0		0 0	0	20.00
21.00	Home Delivered Meals Program	0	0	0		0 0	0	
22.00	Homemaker Service	0	0	0		0 0	0	
23.00	All Others (specify)	0	0	0		0 0	0	
23.50	Tel emedi ci ne	0	0	0		0 0	0	
24.00	Total (sum of lines 1-23)	0	0	0		0 -187, 812		
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0		U	187, 812	25.00
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0.00000	0.00000	00	0. 305443	26.00

ealth Financial Systems NLLOCATION OF GENERAL SERVICE COSTS T	O HHA COST CEN	DEACONESS ITERS	Provider CC	CN: 15-1319 15-7445	Period: From 10/01/2020 To 09/30/2021	Date/Time Pre 2/28/2022 10:	pared:
					Home Health Agency I	PPS	
Cost Center Description	HHA Trial Balance (1)	CAPI TAL RELATED COSTS BLDG & FI XT	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	-
-	0	1.00	4. 00	4A	5.00	7.00	
<ul> <li>Administrative and General</li> <li>Administrative and General</li> <li>Skilled Nursing Care</li> <li>O Skilled Nursing Care</li> <li>O Occupational Therapy</li> <li>O Occupational Therapy</li> <li>O Speech Pathology</li> <li>O Medical Social Services</li> <li>O Home Health Aide</li> <li>O Supplies (see instructions)</li> <li>O Drugs</li> <li>O DME</li> <li>O Home Dialysis Aide Services</li> <li>O Respiratory Therapy</li> <li>O Clinic</li> <li>O Home Delivered Meals Program</li> <li>O Home Service</li> <li>O Home Service</li> <li>O Clinic</li> <li>O Home Delivered Meals Program</li> <li>O Home Service</li> <li>O All Others (specify)</li> <li>So Telemedicine</li> <li>O Total (sum of lines 1-19) (2)</li> <li>O Unit Cost Multiplier: column 26, line 10 vided by the sum of column 26, line 1, rounded to</li> </ul>	0 471, 133 165, 961 103, 596 15, 870 33 46, 102 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0	13, 476 13, 476 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00 139, 170 0 0 0 0 0 0 0 0 0 0 0 0 0	152, 6 471, 1 165, 9 103, 5 15, 8 46, 1	$\begin{array}{cccccccccccccccccccccccccccccccccccc$	29, 298 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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 19.50
6 decimal places. Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CE & SUPPLY	
	8.00	9.00	10. 00	11.00	13.00	14.00	
<ul> <li>Administrative and General</li> <li>O Skilled Nursing Care</li> <li>No Skilled Nursing Care</li> <li>O Ccupational Therapy</li> <li>O Occupational Therapy</li> <li>O Speech Pathology</li> <li>Medical Social Services</li> <li>Home Health Aide</li> <li>O Supplies (see instructions)</li> <li>O Drugs</li> <li>O DME</li> <li>No Home Dialysis Aide Services</li> <li>O Respiratory Therapy</li> <li>O Clinic</li> <li>O Bay Care Program</li> <li>Home Delivered Meals Program</li> <li>No Home Service</li> <li>O All Others (specify)</li> <li>So Telemedicine</li> <li>O Unit Cost Multiplier: column 26, line 1, rounded to</li> </ul>		7, 081 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		38, 0. 38, 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		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 19.50

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

	Financial Systems TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	DEACONESS TERS	Provider C	CN: 15-1310	Po	in Lie eriod:	u of Form CMS-2 Worksheet H-2	
	TTON OF GENERAL SERVICE COSTS T	U HIA COST CEN	TERS	HHA CCN:	15-7445		om 10/01/2020	Part I	pared:
							Home Health Agency I	PPS	
	Cost Center Description	PHARMACY	MEDI CAL	Subtotal	Intern &		Subtotal	Allocated HHA	
			RECORDS & LI BRARY		Residents Cost & Pos Stepdown Adjustments			A&G (see Part II)	
		15.00	16.00	24.00	25.00		26.00	27.00	
$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 50\\ 20. \ 00\\ 21. \ 00\\ \end{array}$	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Home maker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to			285, 447 576, 330 203, 018 126, 728 19, 414 40 56, 396 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			285, 447 576, 330 203, 018 126, 728 19, 414 40 56, 396 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	59, 018 36, 840 5, 644 12	
	6 decimal places. Cost Center Description	Total HHA Costs			<u> </u>				
1 00	Administrative and Cananal	28.00							1 00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places.	743, 869 262, 036 163, 568 25, 058 52 72, 790 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ \end{array}$

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

Health Financial S	2		DEACONESS				In Li	eu of Form CMS-	
ALLOCATION OF GENE BASIS	ERAL SERVICE COSTS	TO HHA COST CEN	TERS STATISTIC	AL Prov		CN: 15-1319 15-7445	Period: From 10/01/202 To 09/30/202	Worksheet H-2 0 Part II 1 Date/Time Pre 2/28/2022 10:	pared:
							Home Health Agency I	PPS	
		CAPI TAL					Agency I		
Cost (	Center Description	RELATED COSTS BLDG & FI XT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci I n		ADMI NI STRATI E & GENERAL (ACCUM. COST	PLANT	LINEN SERVICE	
1.00	1 I Q I	1.00	4.00	5A		5.00	7.00	8.00	1.00
<ul> <li>2.00 Skilled Nur</li> <li>3.00 Physical Th</li> <li>4.00 Occupational</li> <li>5.00 Speech Path</li> <li>6.00 Medical Soc</li> <li>7.00 Home Health</li> <li>8.00 Supplies (s</li> <li>9.00 Drugs</li> <li>10.00 DME</li> <li>11.00 Home Dialys</li> <li>12.00 Respiratory</li> <li>13.00 Private Dut</li> <li>14.00 Clinic</li> <li>15.00 Health Prom</li> <li>16.00 Day Care Pr</li> <li>17.00 Home Delive</li> <li>18.00 Homemaker S</li> <li>19.50 Telemedicin</li> <li>20.00 Total (sum</li> <li>21.00 Total cost</li> <li>22.00 Unit cost m</li> </ul>	nerapy I Therapy I Therapy I Services Aide See instructions) is Aide Services Therapy y Nursing notion Activities rogram sered Meals Program service (specify) Ne of lines 1-19) to be allocated nultiplier	505 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	453, 033 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			471, 1 165, 9 103, 5 15, 8 46, 1 955, 3 213, 3 0, 2232	33 61 96 70 33 30 0 1 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       0         0       0       0         0       0       0         2       0.0000000       0	$\begin{array}{c} 2 & 00 \\ 3 & 00 \\ 4 & 00 \\ 5 & 00 \\ 6 & 00 \\ 7 & 00 \\ 8 & 00 \\ 9 & 00 \\ 10 & 00 \\ 11 & 00 \\ 12 & 00 \\ 13 & 00 \\ 13 & 00 \\ 14 & 00 \\ 15 & 00 \\ 14 & 00 \\ 15 & 00 \\ 14 & 00 \\ 15 & 00 \\ 14 & 00 \\ 15 & 00 \\ 15 & 00 \\ 15 & 00 \\ 15 & 00 \\ 16 & 00 \\ 17 & 00 \\ 18 & 00 \\ 19 & 50 \\ 20 & 00 \\ 21 & 00 \end{array}$
Cost (	Center Description	HOUSEKEEPING (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	CAFETI (GRO SALARI	ISS ES)	NURSI NG ADMI NI STRATI N (NURSE SALARI ES)	SUPPLY (COSTED REQUI S. )	PHARMACY (COSTED REQUIS.)	
1.00 Administrat	ive and General	9.00	10.00	11. (	<u>)0</u> 53.033	13.00 448.2	14.00 05 18,65	15.00 6 0	1.00
<ul> <li>2.00 Skilled Nur</li> <li>3.00 Physical Th</li> <li>4.00 Occupationa</li> <li>5.00 Speech Path</li> <li>6.00 Medical Soc</li> <li>7.00 Home Health</li> <li>8.00 Supplies (s</li> <li>9.00 Drugs</li> <li>10.00 DME</li> <li>11.00 Home Dialys</li> <li>12.00 Respiratory</li> <li>13.00 Private Dut</li> <li>14.00 Clinic</li> <li>15.00 Health Prom</li> <li>16.00 Day Care Pr</li> <li>17.00 Home Delive</li> <li>18.00 Home meaker S</li> <li>19.00 All Others</li> <li>19.50 Telemedicin</li> </ul>	rsing Care herapy I Therapy I Therapy lology ial Services Aide iee instructions) is Aide Services Therapy y Nursing hotion Activities rogram red Meals Program hervice (specify) he of lines 1-19) to be allocated	505 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		4	53, 033 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	448, 2 20, 6	0 0 0 0 0 0 0 0 0 0 0 0 0 0		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 19.00 20.00 21.00

Heal th	Financial Systems		DEACONESS GI	BSON		In Lieu	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS 1	O HHA COST CENT	TERS STATISTICAL	Provider (	CCN: 15-1319	Period:	Worksheet H-2	
BASI S				HHA CCN:	15-7445	From 10/01/2020 To 09/30/2021	Part II Date/Time Pre	narod
				TITIA CON.	15-7445	10 09/30/2021	2/28/2022 10:	
						Home Health	PPS	
						Agency I		
	Cost Center Description	MEDI CAL						
		RECORDS &						
		LI BRARY						
		(GROSS CHARGES)						
		16.00				-		
1.00	Administrative and General	10.00						1.00
2.00	Skilled Nursing Care	0						2.00
3.00	Physical Therapy	0						3.00
4.00	Occupational Therapy	0						4.00
5.00	Speech Pathology	0						5.00
6.00	Medical Social Services	0						6.00
7.00	Home Health Aide	0						7.00
8.00	Supplies (see instructions)	0						8.00
9.00	Drugs	0						9.00
10.00	DME	0						10.00
11.00	Home Dialysis Aide Services	0						11.00
12.00	Respiratory Therapy	0						12.00
13.00	Private Duty Nursing	0						13.00
14.00	Clinic	0						14.00
15.00	Health Promotion Activities	0						15.00
	Day Care Program	0						16.00
	Home Delivered Meals Program	0						17.00
18.00	Homemaker Service	0						18.00
19.00	All Others (specify)	0						19.00
19.50	Telemedicine	0						19.50
20.00 21.00	Total (sum of lines 1-19) Total cost to be allocated	0						20.00 21.00
	Unit cost multiplier	0. 000000						21.00
22.00		0.000000						22.00

Heal th	Financial Systems		DEACONESS	GI BSON		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	ГS		Provider C	CN: 15-1319	Peri od:	Worksheet H-3	
				HHA CCN:	15-7445	From 10/01/2020 To 09/30/2021		
				Title	× XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	Costs (from	Ancillary	Costs (cols.		Per Visit	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)		(col. 3 ÷	
			Part I)	Part II)			col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF T	HE PROGRAM LI	MITATION COST, (	DR BENEFICIARY	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00			743, 86			
2.00	Physical Therapy	3.00	262, 036	0	262, 03	2, 081	125. 92	2.00
3.00	Occupational Therapy	4.00	163, 568	0	163, 56	58 1, 299	125.92	3.00
4.00	Speech Pathology	5.00	25, 058	0	25, 05	58 199	125. 92	4.00
5.00	Medical Social Services	6.00	52		Ę	52 4	13.00	5.00
6.00	Home Health Aide	7.00	72, 790		72, 79	203	358.57	6.00
7.00	Total (sum of lines 1-6)		1, 267, 373					7.00
			.,,		Program Visi			
			1					-
			0000 N (1)			art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
					to	Deducti bl es		
					Deducti bl es Coi nsurance			
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation	-						
8.00	Skilled Nursing Care		99915	0	1, 68	33		8.00
9.00	Physical Therapy		99915	0				9.00
10.00	Occupational Therapy		99915	0				10.00
11.00	Speech Pathology		99915					11.00
12.00	Medical Social Services		99915			2		12.00
13.00	Home Heal th Ai de		99915					13.00
14.00			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					14.00
11.00	Cost Center Description	From Wkst.	Facility	Shared	Total HHA	Total Charges	Ratio (col. 3	11.00
	best benter bescription	H-2 Part I,	Costs (from	Ancillary	Costs (col s.		÷ col. 4)	
		col. 28, line		Costs (from	1 + 2)	Records)		
			Part I)	Part II)		Recordsy		
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Comput	ations						
15.00	Cost of Medical Supplies	8.00		0		0 0		
16.00	Cost of Drugs	9.00		-		1 0	0. 000000	16.00
			Program Visits		Cost of			
			Dom	+ D	Servi ces	Dort D		
	Cast Castas Daarsi ati as	Davet A		t B	Doub A	Part B	Cubi set te	
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to Deductibles &	
			to	Deductibles &		to		
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
		( 00	Coi nsurance 7.00	0.00	0.00	Coi nsurance 10.00	11.00	
		6.00		8.00	9.00			
	PART I - COMPUTATION OF LESSER COST LIMITATION	UF AGGKEGATE	PROGRAW CUST, I	AGGREGATE OF T	TE PRUGRAW LI			
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1, 683			0 525, 803		1.00
2.00	Physi cal Therapy	0	1, 476			0 185, 858		2.00
3.00	Occupational Therapy	0				0 117, 609		3.00
4.00	Speech Pathology	0	159			0 20, 021		4.00
5.00	Medi cal Soci al Servi ces	0				0 26		5.00
6.00	Home Health Aide	0				0 67,770		6.00
7.00	Total (sum of lines 1-6)	0				0 917, 087		7.00

	n Financial Systems		DEACONESS	GIBSON		In Lie	u of Form CMS-	2552-10
APPOR	TIONMENT OF PATIENT SERVICE COST	ΓS		Provider CO	CN: 15-1319 15-7445	Period: From 10/01/2020 To 09/30/2021	Worksheet H-3 Part I Date/Time Pre 2/28/2022 10:	epared:
				Title	XVIII	Home Health Agency I	PPS	00 011
	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physi cal Therapy							9.00
10.00								10.00
11.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							11.00
12.00								12.0
13.00								13.00
14.00	Total (sum of lines 8-13)							14.00
		Prog	ram Covered Ch	arges	Cost of			
					Servi ces			
			-					
				t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
		6.00	Coi nsurance	8.00	9.00	Coi nsurance 10.00	11.00	
	Supplies and Drugs Cost Comput		7.00	0.00	9.00	10.00	11.00	
15.00		0	C	0		0 0		15.00
	Cost of Drugs					0	C	
101 00	Cost Center Description	Total Program						10100
		Cost (sum of						
		col s. 9-10)						
		12.00	1					1
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST,	AGGREGATE OF TH	HE PROGRAM L	IMITATION COST, O	R BENEFICIARY	
	Cost Per Visit Computation	1	1					-
1.00	Skilled Nursing Care	525, 803						1.0
2.00	Physi cal Therapy	185, 858						2.0
3.00	Occupational Therapy	117, 609						3.0
4.00	Speech Pathology	20, 021						4.0
5.00	Medical Social Services	26						5.0
6.00	Home Health Aide	67, 770						6.0
7.00	Total (sum of lines 1-6)	917, 087						7.0
	Cost Center Description	10.00	-					-
	Limitation Cost Commutati	12.00						-
	Limitation Cost Computation Skilled Nursing Care		1					
0 00	Physical Therapy							8.00
		1						
9.00								10.0
9.00 10.00	Occupational Therapy							111 0
9.00 10.00 11.00	Occupational Therapy Speech Pathology							
8.00 9.00 10.00 11.00 12.00	Occupational Therapy Speech Pathology Medical Social Services							11.00
9.00 10.00 11.00 12.00 13.00	Occupational Therapy Speech Pathology Medical Social Services							

Health Financial Systems		DEACONESS	GI BSON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COS	TS		Provider C	CN: 15-1319	Period:	Worksheet H-3	
			HHA CCN:	15-7445	From 10/01/2020 To 09/30/2021	Part II Date/Time Pre 2/28/2022 10:	pared: 06 am
			Title	e XVIII	Home Health	PPS	
					Agency I		
Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
	Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNI SHED	BY SHARED HOSP	ITAL DEPARTME	INTS		
1.00 Physical Therapy	66.00	0. 312382	0		0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy	67.00	0. 000000	0		Ocol. 2, line 3	. 00	2.00
3.00 Speech Pathology	68.00	0. 000000	0		0 col. 2, line 4	. 00	3.00
4.00 Cost of Medical Supplies	71.00	1. 082689	0		0 col. 2, line 1	5.00	4.00
5.00 Cost of Drugs	73.00	0. 415465	0		0 col. 2, line 1	6.00	5.00
-							

ALCHI	Financial Systems DEACONESS GI ATI ON OF HHA REI MBURSEMENT SETTLEMENT	BSON Provider CO	CN: 15-1319	Period:	eu of Form CMS-: Worksheet H-4	
LCOL		HHA CCN:	15-7445	From 10/01/2020 To 09/30/2021	Part I-II	epare
		Title	XVIII	Home Health	PPS	00 0
				Agency I Par	rt B	
			Part A	Not Subject	Subject to	
				to Deductibles &	Deductibles & Coinsurance	
				Coi nsurance		
			1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST( Reasonable Cost of Part A & Part B Services	DMARY CHARGE	ES			+
00	Reasonable cost of services (see instructions)			0 0	0	1.
00	Total charges			0 0	0	2.
00	Customary Charges					
00	Amount actually collected from patients liable for payment for on a charge basis (from your records)	r services		0 0	0	3.
. 00	Amount that would have been realized from patients liable for			0 0	0	4.
	for services on a charge basis had such payment been made in a	accordance				
. 00	with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 00000	0. 000000	5.
. 00	Total customary charges (see instructions)		010000	0 0	-	
00	Excess of total customary charges over total reasonable cost	(complete		0 0	0	7.
. 00	only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete on	lvifline		0	0	8.
. 00	1 exceeds line 6)	ry in time				0.
00	Primary payer amounts			0 0		9.
				Part A Services	Part B Servi ces	
				1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					1 10
). 00 I. 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers			0		10.
2.00	Total PPS Reimbursement - Full Episodes with Outliers			0		
8.00	Total PPS Reimbursement - LUPA Episodes			0		
1.00 5.00	Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers			0		
. 00	Total PPS Outlier Reimbursement - PEP Episodes			0	0 0	
. 00	Total Other Payments			0	0	
. 00	DME Payments			0	0	
. 00 . 00	Oxygen Payments Prosthetic and Orthotic Payments					
. 00	Part B deductibles billed to Medicare patients (exclude coins	urance)		-	0	
. 00	Subtotal (sum of lines 10 thru 20 minus line 21)			0		
. 00	Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)			0	-	
5.00	Coinsurance billed to program patients (from your records)				020,120	
	Net cost (line 24 minus line 25)			0		
	Reimbursable bad debts (from your records)			0	-	27
7.00				0		
7.00 3.00	Reimbursable bad debts for dual eligible beneficiaries (see in		/	0	620 120	
7.00 3.00 9.00			,	0		30.
2.00 3.00 9.00 0.00 0.50	Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	e 27)	,	0	0	30.
7.00 3.00 9.00 0.00 0.50 0.99	Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration	e 27)	,	0 0 0	0 0 0	30. 30.
7.00 3.00 9.00 0.00 0.50 0.99 1.00	Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	e 27)	,	0	0 0 0 620, 120	30. 30. 31.
7.00 8.00 9.00 0.00 0.50 0.99 1.00 1.01 1.01	Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECLFY) Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration	e 27) s)	,		0 0 620, 120 0 0	30. 30. 31. 31. 31.
7.00 8.00 9.00 0.00 0.50 0.99 1.00 1.01 1.02 1.75	Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECLFY) Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Sequestration adjustment for non-claims based amounts (see inst	e 27) s)	,		0 0 620, 120 0 0 0	30. 30. 31. 31. 31. 31.
7.00 8.00 9.00 0.00 0.50 0.99 1.00 1.01 1.02 1.75 2.00	Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECLFY) Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Sequestration adjustment for non-claims based amounts (see instructions) Interim payments (see instructions)	e 27) s)	,		0 0 620, 120 0 0 0 620, 120	30. 30. 31. 31. 31. 31. 32.
	Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECLFY) Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Sequestration adjustment for non-claims based amounts (see inst	e 27) s) structions)	,		0 0 620, 120 0 0 620, 120 0 0 0 0 0 0 0 0 0 0 0	30. 30. 31. 31. 31. 31. 32. 33.

	Financial Systems DEACONESS ( SIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provi der C	CN: 15-1319		eri od:	u of Form CMS-2 Worksheet H-5	–
) PR(	OGRAM BENEFI CLARI ES	HHA CCN:	15-7445	Fr Tc	rom 10/01/2020 09/30/2021	Date/Time Prep	pared
					Home Health	2/28/2022 10:0 PPS	<u>06 am</u>
		Innation	nt Part A	-	Agency I Par	+ B	
		ripatien			i di		
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
00	Total interim payments paid to provider	1.00	2.00	0	3.00	4.00	1.0
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0		020, 120	2.0
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3. C
01	Program to Provider		1	0		0	3. 0
02 03 04				0 0 0		0 0 0	3.0 3.0 3.0
05				0		0	3.0
50	Provider to Program			0		0	3. !
50 51 52 53 54				000000		0 0 0 0	3. 3. 3. 3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0		Ō	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32) TO BE COMPLETED BY CONTRACTOR			0		620, 120	4.
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider						5.
01				0		0	5.
02				0		0	5.
03	Dravidar to Dragram			0		0	5.
50	Provider to Program			0		0	5.
51				0		0	5.
52				0		0	5.
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)						6.
01 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0 0		0	6. 6.
02	Total Medicare program liability (see instructions)			0		620, 120	0. 7.
	,				Contractor Number	NPR Date (Mo/Day/Yr)	
		(	0		1.00	2.00	

Heal th	Financial Systems	DEACONESS	GI BSON			In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1319		ri od:	Worksheet M-1	
			Component	CCN: 15-8524	Fro To	om 10/01/2020 09/30/2021	Date/Time Pre 2/28/2022 10:	
						RHC I	Cost	00 um
		Compensation	Other Costs	Total (col.	1 R	Reclassi fi cat	Recl assi fi ed	
				+ col. 2)		ions	Trial Balance	
				,			(col. 3 +	
							col. 4)	
		1.00	2.00	3.00		4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS			•				
1.00	Physi ci an	0	0		0	0	0	1.00
2.00	Physician Assistant	0	0		0	41, 586	41, 586	2.00
3.00	Nurse Practitioner	218, 684	0	218, 6	84	-41, 586	177, 098	3.00
4.00	Visiting Nurse	0	0		0	0	0	4.00
5.00	Other Nurse	0	0		0	0	0	5.00
6.00	Clinical Psychologist	0	0		0	0	0	6.00
7.00	Clinical Social Worker	0	0		0	0	0	7.00
8.00	Laboratory Techni ci an	0	0		0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0		0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	218, 684	0	218, 6	84	0	218, 684	10.00
11.00	Physician Services Under Agreement	210,004	0	210,0	04	27, 738		
12.00	Physician Supervision Under Agreement	0	0		0	27,738	27,730	12.00
12.00	Other Costs Under Agreement	0	0		0	0	0	12.00
13.00	Subtotal (sum of lines 11 through 13)	0	0		0	-		
14.00		0	-		-	27, 738 -1, 496		
	Medical Supplies	Ű	14, 339					
16.00	Transportation (Health Care Staff)	0	0		0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0	0	0	17.00
	Professional Liability Insurance	0	0		0	0	0	18.00
19.00	Other Health Care Costs	0	0		0	0	0	19.00
20.00	Allowable GME Costs				~ ~		10.010	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14, 339			-1, 496		
22.00	Total Cost of Health Care Services (sum of	218, 684	14, 339	233, 0	23	26, 242	259, 265	22.00
	lines 10, 14, and 21)							
~~ ~~	COSTS OTHER THAN RHC/FQHC SERVICES		-	1				
23.00	Pharmacy	0	0		0	0	0	23.00
24.00	Dental	0	0		0	0	0	24.00
25.00	Optometry	0	0		0	0	0	25.00
25.01	Tel eheal th	0	186, 278	186, 2		-27, 738		
25.02	Chronic Care Management	0	0		0	0	0	25.02
26.00	All other nonreimbursable costs	0	0		0	0	0	26.00
27.00	Nonallowable GME costs							27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	186, 278	186, 2	78	-27, 738	158, 540	28.00
	through 27)							
	FACILITY OVERHEAD			1	-			
29.00	Facility Costs	0	11, 134			-11, 110		29.00
30.00	Administrative Costs	109, 744	199, 147			-8, 019		30.00
31.00	Total Facility Overhead (sum of lines 29 and	109, 744	210, 281	320, 0	25	-19, 129	300, 896	31.00
	30)							
32.00	Total facility costs (sum of lines 22, 28	328, 428	410, 898	739, 3	26	-20, 625	718, 701	32.00
	and 31)			I				

Heal th	Financial Systems	DEACONESS	GI BSON		In Lie	u of Form CMS-	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1319	Peri od:	Worksheet M-1	1
			Component	CCN: 15-8524	From 10/01/2020 To 09/30/2021	Date/Time Pre 2/28/2022 10:	
					RHC I	Cost	_
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 + col. 6)				
		6. 00	7.00	-			
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00	I			
1.00	Physi ci an	0	0				1.00
2.00	Physician Assistant	0	41, 586				2.00
3.00	Nurse Practitioner	0	177, 098				3.00
4.00	Visiting Nurse	0	0				4.00
5.00	Other Nurse	0	0				5.00
6.00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	0	0				7.00
8.00	Laboratory Techni ci an	0	0				8.00
9.00	Other Facility Health Care Staff Costs	0	0				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	218, 684				10.00
11.00	Physician Services Under Agreement	0	27, 738	1			11.00
12.00	Physician Supervision Under Agreement	0	0				12.00
13.00	Other Costs Under Agreement	0	0				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	27, 738				14.00
15.00	Medical Supplies	0	12, 843				15.00
16.00	Transportation (Health Care Staff)	0	0				16.00
17.00	Depreciation-Medical Equipment	0					17.00
	Professional Liability Insurance Other Health Care Costs	0					19.00
	Allowable GME Costs	0	0				20.00
	Subtotal (sum of lines 15 through 20)	0	12, 843				21.00
22.00	Total Cost of Health Care Services (sum of	0	259, 265	•			22.00
22.00	lines 10, 14, and 21)	0	207,200				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			1			
23.00	Pharmacy	0	0				23.00
24.00	Dental	0	0				24.00
25.00	Optometry	0	0				25.00
25.01	Tel eheal th	0	158, 540				25.01
25.02	Chronic Care Management	0	0				25.02
26.00	All other nonreimbursable costs	0	0				26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	158, 540				28.00
	through 27) FACILITY OVERHEAD						-
29.00	Facility Costs	0	24				29.00
30.00	Administrative Costs	-36, 425	264, 447				30.00
31.00	Total Facility Overhead (sum of lines 29 and	-36, 425	264, 471				31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	-36, 425	682, 276				32.00
	and 31)						1

ANALYS							2552-10
	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1319	Period:	Worksheet M-1	
			Component	CCN: 15-8553	From 10/01/2020 To 09/30/2021		
					RHC II	Cost	
		Compensati on	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	400, 829	0				1.00
2.00	Physician Assistant	0	0		0 0	-	2.00
3.00	Nurse Practitioner	112, 581	0			,	3.00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	47, 252	0	47, 25		47, 252	5.00
6.00	Clinical Psychologist	0	0		0 0	0	6.00
7.00	Clinical Social Worker	0	0		0 0	0	7.00
8.00	Laboratory Techni ci an	0	0		0 0	0	
9.00	Other Facility Health Care Staff Costs	0	0		0 0	-	
10.00	Subtotal (sum of lines 1 through 9)	560, 662	0	560, 60			•
11.00	Physician Services Under Agreement	0	0		0 0	-	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	-	
	Other Costs Under Agreement	0	0		0 0		
14.00	Subtotal (sum of lines 11 through 13)	0	0	70 (/	0 0	-	
15.00	Medical Supplies	0	70, 696	70, 69		70, 085	•
16.00	Transportation (Health Care Staff)	0	0		0 0	-	
17.00	Depreciation-Medical Equipment	0	0		0 0	-	
	Professional Liability Insurance Other Health Care Costs	0	0		0 0	0	18.00
19.00 20.00	Allowable GME Costs	0	0		0 0	0	20.00
20.00	Subtotal (sum of lines 15 through 20)	0	70, 696	70, 69	-611	70, 085	•
21.00	Total Cost of Health Care Services (sum of	560, 662	70, 898				21.00
22.00	lines 10, 14, and 21)	500, 002	70, 090	031, 33	-011	030,747	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0 0		24.00
25.00	Optometry	0	0		0 0	0	
25.01	Tel eheal th	0	0		0 0	0	
25.02	Chronic Care Management	0	0		0 0	-	
26.00	All other nonreimbursable costs	0	0		0 0	-	
27.00	Nonallowable GME costs	Ű	0		0	, , , , , , , , , , , , , , , , , , ,	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	•
	through 27)					-	
	FACILITY OVERHEAD						1
29.00	Facility Costs	0	13, 069	13, 00	69 –13, 058	11	29.00
30.00	Administrative Costs	174, 716	282, 992	457, 70	-16, 108	441, 600	30.00
31.00	Total Facility Overhead (sum of lines 29 and	174, 716	296, 061	470, 7	77 -29, 166		31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	735, 378	366, 757	1, 102, 13	35 -29, 777	1, 072, 358	32.00
	and 31)			1	1	1	1

	Financial Systems	DEACONESS			In Lieu	u of Form CMS-	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1319	Peri od:	Worksheet M-7	1
			Component	CCN: 15-8553	From 10/01/2020 To 09/30/2021	Date/Time Pre 2/28/2022 10:	
					RHC II	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
		6. 00	<u>col. 6)</u> 7.00	-			
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				-
1.00	Physi ci an	0	400, 829				1.00
2.00	Physician Assistant	0		1			2.00
3.00	Nurse Practi ti oner	0	-				3.00
4.00	Visiting Nurse	0	0				4.00
5.00	Other Nurse	0	47, 252				5.00
6.00	Clinical Psychologist	0		1			6.00
7.00	Clinical Social Worker	0	0				7.00
8.00	Laboratory Techni ci an	0	0				8.00
9.00	Other Facility Health Care Staff Costs	0	0				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	560, 662				10.00
11.00	Physician Services Under Agreement	0	0				11.00
12.00	Physician Supervision Under Agreement	0	0				12.00
13.00	Other Costs Under Agreement	0	0				13.00
14.00	Subtotal (sum of lines 11 through 13)	0					14.00
15.00	Medical Supplies	0		1			15.00
16.00	Transportation (Health Care Staff)	0		1			16.00
17.00	Depreciation-Medical Equipment	0	0	1			17.00
	Professional Liability Insurance	0	0				18.00
19.00	Other Heal th Care Costs	0	0				19.00
	Allowable GME Costs	0	70.005				20.00
	Subtotal (sum of lines 15 through 20)	0	70, 085	1			21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	630, 747				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						-
23.00	Pharmacy	0	C				23.00
24.00	Dental	0					24.00
25.00	Optometry	0					25.00
25.01	Tel eheal th	0					25.01
	Chronic Care Management	0	0	)			25.02
26.00	All other nonreimbursable costs	0	0				26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.00
	through 27) FACILITY OVERHEAD						-
29.00	Facility Costs	0	11				29.00
30.00	Administrative Costs	-60, 713		•			30.00
31.00	Total Facility Overhead (sum of lines 29 and						31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	-60, 713	1, 011, 645				32.00
	and 31)						1

Health Financial Systems		DEACONESS	GI BSON		In Lie	u of Form CMS-	2552-
ALLOCATION OF OVERHEAD TO HOSPITAL-E	ASED RHC/FQHC	SERVI CES	Provider C		Period:	Worksheet M-2	)
			Component		rom 10/01/2020 o 09/30/2021		narod
			component	CCN. 13-0324	0 077 307 202 1	2/28/2022 10:	
					RHC I	Cost	_
		Number of FTE	Total Visits		Mi ni mum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							-
Positions			1 .	1	1		
. 00 Physi ci an		0.00		., =			1.0
.00 Physician Assistant		0.20					2.0
.00 Nurse Practitioner		0.84					3.0
.00 Subtotal (sum of lines 1 thro	ugh 3)	1.04			2, 184		
00 Visiting Nurse		0.00				0	
00 Clinical Psychologist		0.00				0	
.00 Clinical Social Worker	<b>.</b>	0.00				0	1
.01 Medical Nutrition Therapist (	5,	0.00				0	1
. 02 Diabetes Self Management Trai	ning (FQHC	0.00	0 0			0	7.0
only)			0.454				
00 Total FTEs and Visits (sum of	lines 4	1.04	2, 156			2, 184	8.0
through 7)			0.05			0.05	
0.00 Physician Services Under Agre	ements		205			205	9.0
						1.00	
DETERMINATION OF ALLOWABLE CO	ST APPLICABLE	TO HOSPITAL-BAS	ED RHC/EOHC SE	RVLCES		1.00	
0.00 Total costs of health care se	· · · · · · · · · · · · · · · · · · ·					259, 265	1 10.0
1.00 Total nonreimbursable costs (	•					158, 540	
00 Cost of all services (excluding overhead) (sum of lines 10 and 11)					417, 805		
00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)						0. 620541	
00 Total hospital-based RHC/FQHC overhead - (from Worksheet, M-1, col. 7, line 31)						264, 471	14.
						276, 164	
6.00 Total overhead (sum of lines		5.	,			540, 635	
7.00 Allowable GME overhead (see i							17.
8.00 Enter the amount from line 16						540, 635	18.
9.00 Overhead applicable to hospit	al-based RHC/F	FQHC services (I	ine 13 x line	18)		335, 486	19.0
0.00 Total allowable cost of bosh						50/ 751	20 1

20. 00 Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19) 594, 751 20. 00

Health Financial Systems	DEAC	ONESS	GI BSON		In Lie	u of Form CMS-2	2552-1
ALLOCATION OF OVERHEAD TO HOSPITAL-BAS	ED RHC/FQHC SERVICES		Provider CO		Period: From 10/01/2020	Worksheet M-2	
			Component (	CCN: 15-8553 1	o 09/30/2021	Date/Time Pre 2/28/2022 10:	
					RHC II	Cost	
	Number of	FTE	Total Visits	Producti vi ty	Mi ni mum	Greater of	
	Personn	el		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
	1.00		2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions					T		
. 00 Physi ci an		1.65	5, 611	4, 200			1.0
.00 Physician Assistant		0.00	0	2, 100			2.0
.00 Nurse Practitioner		0.53	1, 972	2, 100			3.0
.00 Subtotal (sum of lines 1 through		2.18	7, 583		8, 043	8, 043	
.00 Visiting Nurse		0.00	0			0	
.00 Clinical Psychologist		0.00	0			0	6.0
.00 Clinical Social Worker		0.00	0			0	7.0
7.01 Medical Nutrition Therapist (FQ		0.00	0			0	7.0
7.02 Diabetes Self Management Trainin	ng (FQHC	0.00	0			0	7.0
onl y)							
3.00 Total FTEs and Visits (sum of li	nes 4	2. 18	7, 583			8, 043	8.0
through 7)							
0.00 Physician Services Under Agreeme	ents		0			0	9.0
						1.00	
DETERMINATION OF ALLOWABLE COST	APPLI CABLE TO HOSPI TAL	-BASE	D RHC/FQHC SEF	RVICES			
0.00 Total costs of health care servi	ces (from Wkst. M-1, c	col. 7,	, line 22)			630, 747	10.0
1.00 Total nonreimbursable costs (fro	m Wkst. M-1, col. 7, I	ine 2	8)			0	11.0
2.00 Cost of all services (excluding					630, 747	12.0	
0 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.0	
4.00 Total hospital-based RHC/FQHC ov							14.0
					654,660	15.0	
6.00 Total overhead (sum of lines 14						1, 035, 558	16.0
7.00 Allowable GME overhead (see ins	ructions)					0	17.(
8.00 Enter the amount from line 16	,					1, 035, 558	18.0
9.00 Overhead applicable to hospital	based RHC/FQHC service	es (lii	ne 13 x line <sup>·</sup>	18)		1, 035, 558	19.0
20 00 Total allowable cost of hospital						1 666 305	20 0

20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19) 1,666,305 20.00

ealth Financial Systems DEACONESS GI ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	BSON Provider C	CN: 15-1310	Period:	u of Form CMS-2 Worksheet M-3	
ERVICES			From 10/01/2020	Date/Time Pre	
	component (	UCIN. 13-0324	To 09/30/2021	2/28/2022 10:	
	Title	XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES					
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro				594, 751	
.00 Cost of injections/infusions and their administration (from W				20, 333	
.00 Total allowable cost excluding injections/infusions (line 1 m	inus line 2)	)		574, 418	
.00 Total Visits (from Wkst. M-2, column 5, line 8) .00 Physicians visits under agreement (from Wkst. M-2, column 5,				2, 184 205	
.00 Total adjusted visits (line 4 plus line 5)	TTHE 9)			205	
.00 Adjusted cost per visit (line 3 divided by line 6)				240.44	
		Cal	culation of Limi		
		Prior to Jan	On or After	On or After	
		1 (Rate	Jan. 1 (Rate	Apr. 1 (Rate	
		Period 1)	Peri od 2)	Period 3)	
		1.00	2.00	3.00	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 contractor)	.6 or your	0.0	0 0.00	272.92	8. (
.00 Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		240. 4	4 240.44	240.44	9.
0.00 Program covered visits excluding mental health services (from records)	contractor	7	0 55	138	10.
<ol> <li>00 Program cost excluding costs for mental health services (line 10)</li> </ol>	9 x line	16, 83	1 13, 224	33, 181	11.
<ol> <li>2.00 Program covered visits for mental health services (from contr records)</li> </ol>	actor		0 0	0	12.
3.00 Program covered cost from mental health services (line 9 x li	ne 12)		0 0	0	13.
4.00 Limit adjustment for mental health services (see instructions	)		0 0	0	14.
5.00 Graduate Medical Education Pass Through Cost (see instruction					15.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2			0 63, 236		16.
6.01  Total program charges (see instructions)(from contractor's re 6.02  Total program preventive charges (see instructions)(from prov			51, 745 2, 695		16. 16.
records)	Lino 14)		2 202		14
6.03 Total program preventive costs ((line 16.02/line 16.01) times 6.04 Total Program non-preventive costs ((line 16 minus lines 16.0			3, 293 42, 784		16. 16.
times .80) (Titles V and XIX see instructions.) 6.05 Total program cost (see instructions)			0 46, 077		16.
7.00 Primary payer amounts			0 40,077		17.
8.00 Less: Beneficiary deductible for RHC only (see instructions)	(from		6, 463		18.
contractor records)					
9.00 Beneficiary coinsurance for RHC/FQHC services (see instructio	ns) (from		8, 517		19.
contractor records) 0.00 Net Medicare cost excluding vaccines (see instructions)			46, 077		20.
1.00 Program cost of vaccines and their administration (from Wkst.	M-4, line		4, 982		20.
16) 2 00 Tatal raimbursable Program cost (line 20 plus line 21)			51,059		22
2.00 Total reimbursable Program cost (line 20 plus line 21) 3.00 Allowable bad debts (see instructions)			51,059		22.
3.01 Adjusted reimbursable bad debts (see instructions)			0		23.
4.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0		23.
5. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0		25.
5.50 Pioneer ACO demonstration payment adjustment (see instruction	s)		0		25.
5.99 Demonstration payment adjustment amount before sequestration			0		25.
6.00 Net reimbursable amount (see instructions)			51, 059		26.
6.01 Sequestration adjustment (see instructions)			0		26.
6.02 Demonstration payment adjustment amount after sequestration			0		26.
7.00 Interim payments			42, 425		27.
8.00 Tentative settlement (for contractor use only)	00 07 1		0		28.
9.00 Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and		8, 634		29.
28) 0.00 Protested amounts (nonallowable cost report items) in accorda	nce with		0		30.
s, ss pristos con amounto (nonarrowabie cost report ritems) in ducorua		1			1 00.

Health Financial Systems CALCULATION OF REIMBURSEMENT SETTLEMENT	DEACONESS GI		CN· 15_1310	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVICES	TOR HOST TRE-DASED RHO/ FURC			From 10/01/2020 To 09/30/2021	Date/Time Pre	pared
				5110	2/28/2022 10:	<u>06</u> am
		litle	XVIII	RHC II	Cost	
					1.00	
DETERMINATION OF RATE FOR HOSPITAL		m Wkot M 2	Line 20)		1 ( ( ( 205	1 1 0
1.00 Total Allowable Cost of hospital- 2.00 Cost of injections/infusions and					1, 666, 305 113, 098	
3.00 Total allowable cost excluding in					1, 553, 207	3.0
4.00 Total Visits (from Wkst. M-2, col		11103 11110 Z,			8, 043	
5.00 Physicians visits under agreement		line 9)			0	5.0
6.00 Total adjusted visits (line 4 plus		ŗ			8, 043	6.0
7.00 Adjusted cost per visit (line 3 d	vided by line 6)				193. 11	7.0
			Cal	culation of Limi	t (1)	
			Prior to Jan	. On or After	On or After	
			1 (Rate	Jan. 1 (Rate	Apr. 1 (Rate	
			Period 1)	Period 2)	Period 3)	
	Dub 100 04 00 000		1.00	2.00	3.00	
8.00 Per visit payment limit (from CMS contractor)	•	0.6 or your	0.0			8.0
9.00 <u>Rate for Program covered visits (</u> CALCULATION OF SETTLEMENT	see instructions)		193. 1	11 193.11	193. 11	9.0
10.00 Program covered visits excluding records)	nental health services (from	contractor	34	41 311	711	10. (
11.00 Program cost excluding costs for 1 10)	mental health services (line	9 x line	65, 85	60, 057	137, 301	11. (
12.00 Program covered visits for mental records)	health services (from contr	actor		0 0	0	12.0
13.00 Program covered cost from mental	nealth services (line 9 x li	ne 12)		0 0	0	13.
14.00 Limit adjustment for mental healt	n services (see instructions	5)		0 0	0	14.0
15.00 Graduate Medical Education Pass T	nrough Cost (see instruction	s)				15.0
16.00 Total Program cost (sum of lines	11, 14, and 15, columns 1, 2	and 3) *		0 263, 209		16. (
16.01 Total program charges (see instru				306, 413		16. (
16.02 Total program preventive charges records)	(see instructions)(from prov	'i der' s		50, 980		16.0
16.03 Total program preventive costs ((				43, 792		16.0
16.04 Total Program non-preventive cost		3 and 18)		154, 190		16.
times .80) (Titles V and XIX see 16.05 Total program cost (see instruct				0 197, 982		16.0
17.00 Primary payer amounts	0113)			0 197, 902		17.0
18.00 Less: Beneficiary deductible for	RHC only (see instructions)	(from		26, 679		18.0
contractor records)		(				
19.00 Beneficiary coinsurance for RHC/F	QHC services (see instructio	ns) (from		45, 723		19.0
contractor records)						
20.00 Net Medicare cost excluding vacci	,	M 4 11		197, 982		20.0
21.00 Program cost of vaccines and thei 16)	auministration (Trom Wkst.	™-4, IIne		35, 167		21.0
22.00 Total reimbursable Program cost (	ine 20 plus line 21)			233, 149		22.0
23.00 Allowable bad debts (see instruct				200, 147		23.
23.01 Adjusted reimbursable bad debts (				0		23.
24.00 Allowable bad debts for dual elig	,	ructions)		0		24.
25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIO	NS) (SPECI FY)			0		25.
25.50 Pioneer ACO demonstration payment		is)		0		25.
25.99 Demonstration payment adjustment				0		25.
26.00 Net reimbursable amount (see inst				233, 149		26.
26.01 Sequestration adjustment (see ins 26.02 Demonstration payment adjustment a				0		26. 26.
26.02  Demonstration payment adjustment ; 27.00  Interim payments	amount arter sequestration			221, 306		20.
28.00 Tentative settlement (for contrac	tor use only)			221, 300		27.
29.00 Balance due component/program (li		02, 27. and		11, 843		20.
28)	20100 20101, 201	,, and		, 510		
30.00 Protested amounts (nonallowable c	ost report items) in accorda	nce with		0		30.

Heal th	Financial Systems DEACONESS	GI BSON		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider C	CN: 15-1319	Peri od:	Worksheet M-4	
		Component	CCN: 15-8524	From 10/01/2020 To 09/30/2021		
		Title	XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00 2.00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	218, 684 0. 002620				1.00 2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	573	1, 02	28 270	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	5, 037	1, 95	6 0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	5, 610				5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	259, 265	259, 26	259, 265	259, 265	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	335, 486				
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 021638				
9.00	Overhead cost - injection/infusion (line 7 x line 8)	7, 259				9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	12, 869		15 619		10100
11.00	Total number of injections/infusions (from your records)	34		51 16		
12.00	Cost per injection/infusion (line 10/line 11)	378.50				12.00
13.00	Number of injection/infusion administered to Program beneficiaries	9		3 3	0	
	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	_	
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	3, 407	1, 45	59 116	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02,		20, 33	33		15.00
16.00	line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		4, 98	32		16.00

Heal th	Financial Systems DEACONESS	GI BSON		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider C	CN: 15-1319	Peri od:	Worksheet M-4	
		Component	CCN: 15-8553	From 10/01/2020 To 09/30/2021		pared: 06 am
-		Title	XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00 2.00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	560, 662 0. 003430				1.00 2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1, 923	7,48	95	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	18, 076	15, 22	29 0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	19, 999	22, 7	7 95	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	630, 747	630, 74	630, 747	630, 747	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1, 035, 558	1, 035, 55	58 1, 035, 558	1, 035, 558	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 031707	0. 03601	6 0.000151	0. 000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	32, 834			0	
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	52, 833			0	
11.00	Total number of injections/infusions (from your records)	122			0	
12.00	Cost per injection/infusion (line 10/line 11)	433.06				12.00
13.00	Number of injection/infusion administered to Program beneficiaries	39	14		0	
	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	_	
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	16, 889	18, 19	94 84	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02,		113, 09	98		15.00
16.00	line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		35, 16	57		16.00

Health Financial Systems	DEACON	NESS GI BSON	Inlie	eu of Form CMS-2	2552-10
	IOSPI TAL-BASED RHC/FQHC PROVI DER FOR	Provi der CCN: 15-1319	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROG			From 10/01/2020		
SERVICES RENDERED TO TROC	INAM DENETTOTANTES	Component CCN: 15-8524	To 09/30/2021	Date/Time Pre	pared:
				2/28/2022 10:0	06 am
			RHC I	Cost	
			Pai	rt B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00 Total interim paym	ents paid to hospital-based RHC/FQHC			42, 425	1.00
	ayable on individual bills, either su	bmitted or to be submitted to	b	0	2.00
the contractor for	services rendered in the cost report	ing period. If none, write			
"NONE" or enter a	zero	51			
	ch retroactive lump sum adjustment am	ount based on subsequent			3.00
	terim rate for the cost reporting per				
	write "NONE" or enter a zero. (1)				
Program to Provider					
3.01				0	3.01
3. 02				0	3.02
3. 03				0	3.03
3. 04				0	3.03
3. 05				0	3.04
Provider to Program	n			0	3.05
<u> </u>	1			0	2 50
3. 50 3. 51					3.50
				0	3.51
3. 52				-	3.52
3. 53				0	3.53
3.54		>		0	3.54
	ines 3.01-3.49 minus sum of lines 3.5			0	3.99
	ents (sum of lines 1, 2, and 3.99) (t	ransfer to Worksheet M-3, li	ne	42, 425	4.00
27)					
TO BE COMPLETED BY					
	ch tentative settlement payment after		of		5.00
	one, write "NONE" or enter a zero. (1	)			
Program to Provider					
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program	n				
5.50				0	5.50
5. 51				0	5.51
5. 52				0	5.52
5.99 Subtotal (sum of l	ines 5.01-5.49 minus sum of lines 5.5	0-5.98)		0	5.99
	tlement amount (balance due) based on	the cost report. (1)			6.00
6.01 SETTLEMENT TO PROV				8, 634	6.01
6.02 SETTLEMENT TO PROG	RAM			0	6.02
7.00 Total Medicare pro	gram liability (see instructions)			51, 059	7.00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	

AMALYSIS OF PAYMENTS TO HOSPITAL-BASED REC/FORC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES       Provider CCN: 15-1319 Component CCN: 15-6553       Period: To 00/12/2021       Worksheet M-5 Date/Time Propared: 2/22/2021 (0.66 am Provider CCN: 15-6553)         1:00       Total interim payments paid to hospital-based REC/FORC       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       Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero       0       2.00         3:01       0.01       Uss separately each retroactive iump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero       0       0       3.00         3:01       0.01       07/29/2021       49,100       3.01         3:02       0       3.00       0       3.00         3:03       0       07/29/2021       49,100       3.01         3:04       0       07/29/2021       49,100       3.01         3:05       0       3.05       0       3.05         0       0       0       3.05       0       3.05         1:00       0       0       3.01	Hoal th	Financial Systems DEACONESS		Inlie	u of Form (MS_2	2552-10
SERVICES RENDERED TO PROGRAM BENEFICIARIES         Component CCN: 15-853         From         10/01/2020 To 09/30/2021         Date/Time Prepared: 2/28/2022 10:06 an           1.00         Total interim payments paid to hospital-based REC/FORC         mm/dd.yyyy         nm/dd.yyy         nm/dd.yyy           2.00         Interim payments paid to hospital-based REC/FORC         1.00         2.00         172, 206         1.00           3.01         List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)         07/29/2021         49, 100         3.00           3.03         0.04         0         3.02         0.02         3.03         3.04         3.04         3.05           3.04         0         3.05         0         0.102         3.06         3.06         3.05           700 der to Program         0         0.3.04         0         3.05         3.06         3.05           5.05         Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.96)         0         3.50         3.54         3.50           5.00         List separately each tentative settlement payment after desk review. Al so show date of sch payments (sum of lines 3.50-3.96)         0         3.50           5.01         Dis						552-10
Component CON: 15-853         To         09/30/2021         Date/Time Prepared: 2/28/2022 10:06 an 2/28/2022 10:06			PLOVIDEL CCN. 15-1319			
Image: constraint of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second sec	SERVIC	ES REINDERED TO PROGRAM DENEFTCTARTES	Component CCN: 15-8553			pared:
Part B         Part B           1.00         Total interim payments paid to hospital-based RHC/FOHC         1.00         2.00           1.00         Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.         1.00         1.72, 206         1.00         2.00           2.00         its caparately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)         07/29/2021         49, 100         3.01           3.01         00         2.00         0.01         3.02         0.01         3.02           3.01         00         2.02         49, 100         3.01         3.03         0.01         3.02         0.01         3.03           3.02         0.03         3.04         0.03         3.04         0.03         3.05           9         Provider to Program         0         3.50         3.50         3.51         0.01         3.52           3.52         0.01         0         3.52         0.01         3.52         3.53         3.54         0.01         3.54         0.01         3.52         3.53         3.54         0.01						
mm/dd/yyyy         Amount           1.00         Total interim payments paid to hospital-based RHC/FOHC         1.00         2.00           2.00         Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.         1.00         2.00           3.00         List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Al so show date of each payment. If none, write "NONE" or enter a zero. (1)         3.00           Program to Provider         07/29/2021         49,100         3.01           3.01         07/29/2021         49,100         3.02           3.02         0         3.04         3.04         3.04           3.04         0         3.04         3.04         3.04           3.05         Provider to Program         0         3.50         3.65           3.04         0         3.54         3.65         3.65           3.04         0         3.54         3.64         3.64           3.05         0         3.54         3.64         3.65           3.04         0         3.54         3.65         3.53           3.65         0         3.54         3				RHC II	Cost	
Image: constraint of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second sec				Par	rt B	
1:00       Total Interim payments paid to hospital-based RIC/FORC       172,206       1.00         2:00       Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero       1.00       2.00         3:00       List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       3.00         Program to Provider       07/29/2021       49,100       3.01         3:04       07/29/2021       49,100       3.02         3:05       00       3.02       3.03         3:04       0       3.04       3.05         3:05       0       0       3.04         3:06       0       3.04       3.05         3:06       0       3.05       3.04         3:07       0       0       3.05         3:08       0       3.04       3.05         3:09       0       3.06       3.05         3:51       0       3.51       3.52         3:53       0       3.54       49,100       3.54         3:54       0       0       1.50       5.00				mm/dd/yyyy	Amount	
2.00       Interim payments payable on individual bills, either submitted or to be submitted to 'NONE" or enter a zero.       0       2.00         3.00       List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       0       3.00         Program to Provider       0       0       3.01         3.01       0       0       3.01         9       0       0       3.01         3.00       0       0       3.01         9       0       0       3.01         3.00       0       3.01       0         3.01       0       0       3.01         3.02       0       3.01       0         3.03       0       3.01       0         3.04       0       3.01       0         3.05       0       3.01       0         3.06       0       3.51       0       3.51         3.53       0       3.51       0       3.51         3.54       0       3.51       0       3.51         3.59       Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)       49       49       0 <td></td> <td></td> <td></td> <td>1.00</td> <td>2.00</td> <td></td>				1.00	2.00	
2.00       Interim payments payable on individual bills, either submitted or to be submitted to 'NONE" or enter a zero.       0       2.00         3.00       List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       0       3.00         Program to Provider       0       0       3.01         3.01       0       0       3.01         9       0       0       3.01         3.00       0       0       3.01         9       0       0       3.01         3.00       0       3.01       0         3.01       0       0       3.01         3.02       0       3.01       0         3.03       0       3.01       0         3.04       0       3.01       0         3.05       0       3.01       0         3.06       0       3.51       0       3.51         3.53       0       3.51       0       3.51         3.54       0       3.51       0       3.51         3.59       Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)       49       49       0 <td>1.00</td> <td>Total interim payments paid to hospital-based RHC/FQHC</td> <td></td> <td></td> <td>172, 206</td> <td>1.00</td>	1.00	Total interim payments paid to hospital-based RHC/FQHC			172, 206	1.00
the contractor for Services rendered in the cost reporting period. If none, write "NOWE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent program to Provider 3.00 3.01 3.02 3.03 3.04 3.05 Provider to Program 5.50 5.51 5.52 5.00 5.51 5.52 5.00 5.51 5.52 5.00 5.51 5.52 5.00 5.51 5.52 5.00 5.51 5.52 5.00 5.51 5.52 5.00 5.01 5.01 5.01 5.02 5.02 5.02 5.03 5.02 5.03 5.03 5.03 5.04 5.00 5.01 5.02 5.03 5.03 5.04 5.00 5.01 5.02 5.03 5.02 5.03 5.04 5.00 5.01 5.02 5.03 5.02 5.02 5.03 5.04 5.00 5.01 5.02 5.02 5.03 5.02 5.03 5.04 5.00 5.01 5.02 5.03 5.02 5.03 5.02 5.03 5.04 5.00 5.01 5.02 5.03 5.02 5.03 5.02 5.03 5.04 5.00 5.01 5.02 5.03 5.02 5.03 5.02 5.03 5.02 5.03 5.03 5.03 5.04 5.00 5.01 5.02 5.03 5.02 5.03 5.02 5.03 5.04 5.01 5.02 5.03 5.02 5.03 5.03 5.04 5.01 5.02 5.03 5.02 5.03 5.03 5.03 5.04 5.01 5.02 5.03 5.02 5.03 5.03 5.04 5.01 5.02 5.03 5.03 5.04 5.01 5.02 5.03 5.02 5.03 5.02 5.03 5.02 5.03 5.04 5.01 5.02 5.03 5.02 5.03 5.02 5.03 5.03 5.04 5.01 5.02 5.03 5.02 5.03 5.02 5.03 5.02 5.03 5.03 5.03 5.04 5.04 5.05 5.04 5.05 5.05 5.05 5.05 5.05 5.05 5.02 5.02 5.03 5.02 5.03 5.04 5.04 5.05 5.05 5.04 5.05 5.05 5.05 5.05 5.05 5.05 5.02 5.02 5.02 5.03 5.02 5.03 5.03 5.04 5.05 5.04 5.05 5.05 5.05 5.05 5.05 5.02 5.02 5.02 5.02 5.03 5.02 5.03 5.03 5.03 5.04 5.04 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05 5.05	2.00		tted or to be submitted to		0	2.00
"NONE" or enter a zero         3.00           0.0         List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)         9709729/2021         49,100         3.01           9.01         9.01         07/29/2021         49,100         3.02         3.02           3.03         0.03         0.04         0.01         3.02         3.02           3.03         0.04         0.01         3.04         0.01         3.04           3.04         0.03         3.04         0.03         3.05           9         Provider to Program         0.3.50         3.51         3.51           3.55         0.03         3.52         3.53         3.54         0.03         3.55           9.9         Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)         49,100         3.99         49,100         3.99           10         BE coMPLETED BY CONTRACTOR         5.00         5.00         5.00         5.00         5.01         5.02         5.03           10         BE complexitive settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)         5.00         5.00         5.01						
3.00         List separately each retroactive lump sum adjustment amount based on subsequent payment. If none, write "NONE" or enter a zero. (1)         3.00           Program to Provider         07/29/2021         49,100         3.01           3.01         03.03         0         3.00         3.01           3.05         07/29/2021         49,100         3.01         3.03           3.05         07/29/2021         49,100         3.03           3.05         0.03         3.03         0.03         3.04           3.05         0.03         3.04         0.3.04         3.04           3.05         0.03         3.04         0.3.05         3.04           3.05         0.05         0.3.51         0.05         3.52           3.54         0.03         3.53         0.05         3.54           00         Total interi mayments (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)         49,100         3.99           10         E COMPLETED BY CONTRACTOR         0.00         5.00         5.01           10         E COMPLETED BY CONTRACTOR         0.00         5.00         5.01           5.02         0         5.01         0.5.01         5.01           5.03         0         5.52 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
revision of the interim rate for the cost reporting period. Also show date of each         or isomethyle         or isomethyle <thor isomethyle<="" th=""> <tho isomethyle<="" th="">         or i</tho></thor>	3.00		t based on subsequent			3.00
payment. If none, write "NONE" or enter a zero. (1)"         Order           3.01         07/29/2021         49,100         3.01           3.02         03.03         04         0         3.03           3.04         0         3.03         0.03         3.03           3.05         0         0.3.03         3.04         0.03         3.03           3.06         0         3.03         3.04         0.03         3.03           3.06         0         3.03         3.04         0.03         3.05           3.06         0         3.05         0.03         3.05         3.05           3.05         0         3.50         3.51         0.03         3.51           3.50         0         3.52         0.03         3.53           3.54         0         3.53         3.54         0.03         3.53           3.59         Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)         4.90         3.50         3.50           5.00         Total interim payments (sum of lines 1.2, and 3.99) (transfer to Worksheet M-3, line 221,306         4.00         5.00           5.01         Extremative "NONE" or enter a zero. (1)         0         5.50         5.01         5.01<						
Program to Provider         OT/29/2021         49,100         3,01           3.01         07/29/2021         49,100         3,02         3,02           3.03         0         0         3,02         0         3,02           3.04         0         0         3,04         0         3,04           3.04         0         0         3,04         0         3,04           3.05         0         0         3,04         0         3,04           3.05         0         3,04         0         3,04         0         3,04           3.05         0         3,04         0         3,04         0         3,04           3.05         0         3,54         0         3,51         3,53         3,54           3.99         Subtotal (sum of lines 1, 2, and 3,99) (transfer to Worksheet M-3, line         221,306         4,00           27)         0         16         0         5,01         5,02         5,02           5.00         11 f sea paratel y each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)         5,01         5,02         5,52           5.01         0         5,50         5,50						
3.01       07/29/2021       49,100       3.01         3.02       0       3.02       0       3.02         3.04       0       3.04       0       3.04       0       3.03         3.04       0       3.04       0       3.04       0       3.03         3.04       0       3.04       0       3.04       0       3.03         3.04       0       3.04       0       3.04       0       3.03         3.05       0       3.05       0       3.50       0       3.51         3.52       0       3.52       0       3.52       0       3.53         3.54       0       7.52       0       3.54       0       3.53         3.59       Subtotal (sum of Lines 3.01-3.49 minus sum of Lines 3.50-3.98)       49,100       3.99       1.99       221,306       4.00         27)       Total interim payments (sum of Lines 1, 2, and 3.99) (transfer to Worksheet M-3, Line       221,306       5.00         20       Total interim payments (sum of Lines 1, 2, and 3.99)       1.90       5.00       5.00       5.00         210       Program to Provider       0       5.01       5.00       5.00       5.03       5.50<						
3.02       0       3.02         3.03       0       3.03         3.04       0       3.03         3.05       0       3.05         Provider to Program       0       3.50         3.50       0       3.51         3.52       0       3.53         3.54       0       3.53         3.54       0       3.53         3.54       0       3.53         3.54       0       3.54         0.00       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line       221, 306         27)       TO BE COMPLETED BY CONTRACTOR       5.00         5.00       Lis separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       5.00         Program to Provider       0       5.01         5.01       0       5.02         5.02       0       5.03         9       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.50         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52 <td>3 01</td> <td></td> <td></td> <td>07/29/2021</td> <td>49 100</td> <td>3 01</td>	3 01			07/29/2021	49 100	3 01
3.03       0       3.03         3.04       0       3.03         3.05       0       3.04         Provider to Program       0       3.05         3.50       0       3.50         3.51       0       3.51         3.52       0       3.52         3.53       0       3.54         3.99       Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)       49,100         4.00       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line       221,306         27)       70 BE COMPLETED BY CONTRACTOR       5.00         5.00       List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       5.00         Program to Provider       0       5.03         7.00       Provider to Program       0         5.50       5.51       0       5.50         5.52       9       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.50         5.50       0       5.51       0       5.52       5.99         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       11.843       6.01         6.01				0172772021		
3.04         0         3.04           3.05         Provider to Program         0         3.06           3.50         0         3.51         0         3.51           3.52         0         3.51         3.52         0         3.52           3.54         0         3.54         0         3.54           3.99         Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)         49,100         3.99           4.00         Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line         221,306         4.00           27)         To BE COMPLETED BY CONTRACTOR         5.00         1.1st separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)         5.00         5.00           Program to Provider         0         5.01         5.02         5.03           5.03         0         5.01         0         5.03           5.50         0         5.50         5.50         5.50         5.50           5.50         0         5.51         0         5.52         5.52         5.52         5.52         5.52         5.52         5.52         5.52         5.52         5.52         5.52         5.52						
3.05       Provider to Program       0       3.05         7.00       Forwider to Program       0       3.50         7.00       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 221, 306       0       3.50         7.00       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)       0       5.00         7.00       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)       5.00         7.00       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 221, 306       5.00         7.00       List separately each tentative settlement payment after desk review. Also show date of exch payment. If none, write "NONE" or enter a zero. (1)       5.00         8.01       Program to Provider       0       5.01         5.01       0       5.02       0       5.02         5.01       0       5.02       0       5.03         8       0       5.50       5.50       5.50       5.50       5.50         5.52       S.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         5.99       Subtotal (sum of lines s.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         6.02       SETTLEMENT TO PROGRAM						
Provider to Program         0         3. 50           3. 50         0         3. 50           3. 52         0         3. 51           3. 52         0         3. 52           3. 54         0         3. 54           3. 99         Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98)         49, 100         3. 59           4.00         Total interim payments (sum of lines 1, 2, and 3. 99) (transfer to Worksheet M-3, line         221, 306         4.00           27)         TO BE COMPLETED BY CONTRACTOR         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.51         5.52         5.99         5.90         5.90         5.90						
3.50       0       3.50         3.51       0       3.51         3.52       3.53       0       3.51         3.54       0       3.53         3.54       0       3.53         3.59       Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)       49,100       3.99         4.00       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 221,306       4.00         27)       TO BE COMPLETED BY CONTRACTOR       5.00         Each payment. If none, write "NONE" or enter a zero. (1)       5.00         Program to Provider       0       5.01         5.00       5.01       5.02         5.01       0       5.01         5.02       0       5.50         5.03       0       5.51         5.04       0       5.51         5.05       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       11,843       6.01         6.02       SETTLEMENT TO PROGRAM </td <td>3.05</td> <td></td> <td></td> <td></td> <td>0</td> <td>3.05</td>	3.05				0	3.05
3.51       0       3.51         3.52       0       3.53         3.54       0       3.53         3.99       Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)       49,100         4.00       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line       221,306         70       BE COMPLETED BY CONTRACTOR       221,306         5.00       List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       5.00         Program to Provider       0       5.01         5.01       0       5.03         5.02       0       5.03         9       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.51         5.52       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         6.00       SETTLEMENT TO PROVIDER       0       5.90         6.01       SETTLEMENT TO PROVIDER       0       6.00         6.02       SETTLEMENT TO PROGRAM       0       6.02 <td>0 50</td> <td>Provider to Program</td> <td></td> <td>-</td> <td></td> <td>0 50</td>	0 50	Provider to Program		-		0 50
3.52       3.53         3.54       0         3.59       Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)       49,100         4.00       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line       221,306         70       BE COMPLETED BY CONTRACTOR       221,306         5.00       List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       5.00         Program to Provider       0       5.01         5.01       5.02       5.03         Provider to Program       0       5.50         5.51       0       5.50         5.52       0       5.50         5.52       0       5.50         5.52       0       5.50         5.52       0       5.50         5.52       0       5.50         5.52       0       5.50         5.52       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.59         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       6.00         6.01       SETTLEMENT TO PROGRAM       0       6.02						
3.53       .54       0       3.53         3.99       Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)       49,100       3.63         70       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line       221,306       4.00         27)       To BE COMPLETED BY CONTRACTOR       221,306       4.00         5.00       List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       5.00         Program to Provider       0       5.01         5.01       0       5.01         5.02       0       5.03         Provider to Program       0       5.50         5.50       0       5.50         5.52       0       5.50         5.52       0       5.50         5.52       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         5.99       Subtotal (sum of lines 70 PROVIDER       11,843       6.01         6.01       SETTLEMENT TO PROGRAM       0       233,149       7.00         6.02       SETTLEMENT TO PROGRAM       233,149       7.00       2.00						
3.54       0       3.54         3.99       Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)       49,100         4.00       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line       221,306         70       ECOMPLETED BY CONTRACTOR       221,306         10 BE COMPLETED BY CONTRACTOR       5.00         List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       5.00         Program to Provider       0       5.01         5.02       0       5.01         5.03       0       5.02         9       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.50         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       6.01         6.02       SETTLEMENT TO PROGRAM       23,149       7.00         7.00       Total Medicare program liability (see instructions)       23,149       7.00         0       1.00       2.00       1.00       2.00					-	
3.99       Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)       49,100       3.99         4.00       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line       221,306       4.00         27)       TO BE COMPLETED BY CONTRACTOR       5.00       1ist separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       5.00       5.01         9       Program to Provider       0       5.01         5.01       0       5.01       5.02         5.02       0       5.03         9       Provider to Program       0       5.50         5.50       0       5.50       5.50         5.52       0       5.50       5.50         9       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.50         5.02       0       5.59       0       5.99         6.00       Betrmined net settlement amount (balance due) based on the cost report. (1)       6.00       6.00         6.01       SETTLEMENT TO PROVIDER       0       11,843       6.01         6.02       SETTLEMENT TO PROKEM       233,149       7.00         7.00       Total Medicare program liability (see instructions)       233,149					-	
4.00       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line       221, 306       4.00         27)       TO BE COMPLETED BY CONTRACTOR       5.00       5.00       5.00       5.00         List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       5.00       5.00       5.01         Program to Provider       0       5.01       5.00       5.02       5.03         9       Provider to Program       0       5.50       5.50       5.50         5.90       9       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.59         5.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       5.99         6.00       Dettruit TO PROKIDER       0       5.99       6.00         6.01       SETTLEMENT TO PROKIDER       0       6.00         6.02       SETTLEMENT TO PROKIDER       0       6.02         7.00       Total Medicare program liability (see instructions)       233, 149       7.00         0       1.00       2.00       2.00       1.00       2.00					-	
27)         TO BE COMPLETED BY CONTRACTOR         5.00           List separately each tentative settlement payment after desk review. Al so show date of each payment. If none, write "NONE" or enter a zero. (1)         5.00           Program to Provider         0           5.01         0           5.02         0           5.03         0           Provider to Program         0           5.50         0           Provider to Program         0           5.51         0           5.52         0           5.54         0           5.55         0           5.50         0           9         Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)           6.00         Determined net settlement amount (balance due) based on the cost report. (1)           6.01         SETTLEMENT TO PROVIDER           6.02         SETTLEMENT TO PROGRAM           7.00         Total Medicare program liability (see instructions)           0         1.00           0         1.00						
TO BE COMPLETED BY CONTRACTOR       5.00         List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       5.00         Program to Provider       0         5.01       0         5.02       0         5.03       0         Provider to Program       0         5.50       0         9       0         5.51       0         5.52       0         5.52       0         5.53       0         5.54       0         5.55       0         5.50       0         5.51       0         5.52       0         5.53       0         5.54       0         5.55       0         5.50       0         5.51       0         5.52       0         5.53       0         5.54       0         5.55       0         5.50       0         5.51       0         5.52       0         5.53       0         5.54       0         5.55       0	4.00		sfer to Worksheet M-3, line	Э	221, 306	4.00
5.00       List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       5.00       5.01         Program to Provider       0       5.01       0       5.01         5.02       0       0       5.02       0       5.03         Provider to Program       0       5.50       0       5.50       5.51       0       5.51         5.52       0       0       5.52       0       5.52       5.52       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52       5.99       6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       6.02       5.99       6.00       6.02       5.51       6.00       6.02       5.93       6.00       6.02       5.93       6.01       6.02       6.02       6.02       6.02       6.02       6.02       6.02       6.02       6.02       6.02       6.02       233,149       7.00       6.00         O       1.00       2.00       10       2.00       10       10       6.02						
each payment. If none, write "NONE" or enter a zero. (1)         o           Program to Provider         0           5.01         0           5.02         0           5.03         0           Provider to Program         0           5.50         0           5.51         0           5.52         0           5.51         0           5.52         0           5.52         0           5.52         0           5.52         0           5.52         0           5.53         0           5.54         0           5.55         0           5.59         0           Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)         0           0         5.52           5.99         Subtotal (sum of PROVIDER           6.00         5.59           6.01         SETTLEMENT TO PROVIDER           6.02         SETTLEMENT TO PROGRAM           7.00         Total Medicare program Hability (see instructions)           0         1.00         2.00				1		
Program to Provider       0       5.01         5.02       0       5.02         5.03       0       5.02         Provider to Program       0       5.03         5.50       0       0         5.51       0       0         5.52       0       0         5.52       0       5.51         5.52       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.59         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       6.00         6.01       SETTLEMENT TO PROVIDER       11,843       6.01         6.02       SETTLEMENT TO PROGRAM       0       6.02         7.00       Total Medicare program liability (see instructions)       233,149       7.00         0       1.00       2.00       1       0	5.00		sk review. Also show date o	of		5.00
5.01       0       5.01         5.02       0       5.02         5.03       0       5.02         9       Provi der to Program       0       5.50         5.50       0       5.51         5.52       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.99         6.00       Determined net settlement amount (bal ance due) based on the cost report. (1)       6.00       6.00         6.01       SETTLEMENT TO PROVIDER       11,843       6.01         6.02       SETTLEMENT TO PROGRAM       0       6.02         7.00       Total Medicare program liability (see instructions)       233,149       7.00         Contractor NPR Date (Mo/Day/Yr)         0       1.00       2.00						
5.02       0       0       5.02         5.03       Provider to Program       0       5.03         5.50       0       0       5.51         5.52       0       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       6.00         6.01       SETTLEMENT TO PROVIDER       0       6.02       SETTLEMENT TO PROVIDER       6.02         7.00       Total Medicare program liability (see instructions)       233,149       7.00       6.02         7.00       Total Medicare program liability (see instructions)       0       1.00       2.00       1		Program to Provider				
5.03       Provider to Program       0       5.03         5.50       0       0       5.50         5.51       0       0       5.50         5.52       0       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       0         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       6.00         6.01       SETTLEMENT TO PROVIDER       0       6.02         6.02       SETTLEMENT TO PROGRAM       0       6.02         7.00       Total Medicare program liability (see instructions)       233,149       7.00         O       1.00       2.00						
Provider to Program         0         5.50           5.50         0         0         5.50           5.51         0         0         5.51           5.52         0         5.52         0         5.52           5.99         Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)         0         5.99           6.00         Determined net settlement amount (balance due) based on the cost report. (1)         6.00         5.99           6.01         SETTLEMENT TO PROVIDER         11,843         6.01           6.02         SETTLEMENT TO PROGRAM         0         6.02           7.00         Total Medicare program liability (see instructions)         233,149         7.00           Contractor NPR Date (Mo/Day/Yr)           0         1.00         2.00						
5.50       0       5.50         5.51       0       5.51         5.52       0       5.51         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.99         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       5.99         6.01       SETTLEMENT TO PROVIDER       11,843       6.01         6.02       SETTLEMENT TO PROGRAM       0       6.02         7.00       Total Medicare program liability (see instructions)       233,149       7.00         Contractor NUMBER         0       1.00       2.00	5.03				0	5.03
5.51		Provider to Program				
5.52	5.50				0	5.50
5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       0       5.99         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       6.00         6.01       SETTLEMENT TO PROVIDER       11,843       6.01         6.02       SETTLEMENT TO PROGRAM       0       6.02         7.00       Total Medicare program liability (see instructions)       233,149       7.00         Contractor NPR Date (Mo/Day/Yr)         0       1.00       2.00	5.51				-	5.51
6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       6.00         6.01       SETTLEMENT TO PROVIDER       11,843       6.01         6.02       SETTLEMENT TO PROGRAM       0       6.02         7.00       Total Medicare program liability (see instructions)       233,149       7.00         Contractor NPR Date (Mo/Day/Yr)         0       1.00       2.00	5.52				0	
6.01       SETTLEMENT TO PROVIDER       11,843       6.01         6.02       SETTLEMENT TO PROGRAM       0       6.02         7.00       Total Medicare program liability (see instructions)       233,149       7.00         Contractor NUMber       NPR Date (Mo/Day/Yr)         0       1.00       2.00	5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5	. 98)		0	5.99
6.02     SETTLEMENT TO PROGRAM     0     6.02       7.00     Total Medicare program liability (see instructions)     233,149     7.00       Contractor Number (Mo/Day/Yr)       0     1.00     2.00	6.00	Determined net settlement amount (balance due) based on th	e cost report. (1)			6.00
6.02     SETTLEMENT TO PROGRAM     0     6.02       7.00     Total Medicare program liability (see instructions)     233,149     7.00       Contractor Number (Mo/Day/Yr)       0     1.00     2.00	6.01	SETTLEMENT TO PROVIDER			11, 843	6.01
7.00         Total Medicare program liability (see instructions)         233,149         7.00            Contractor Number         NPR Date (Mo/Day/Yr)         (Mo/Day/Yr)           0         1.00         2.00						6.02
Contractor         NPR Date           Number         (Mo/Day/Yr)           0         1.00         2.00					233, 149	
Number         (Mo/Day/Yr)           0         1.00         2.00				Contractor		
0 1.00 2.00						
			0			
	8.00	Name of Contractor				8.00