This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0102 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/30/2022 10:09 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/30/2022 Time: 10:09 am] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[19] 19. NPR Date:
[19] 19. NPR Date:
[10] 19. NPR Date:
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[12] 19. NPR Date:
[13] 19. NPR Date:
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[15] 19. NPR Date:
[16] 19. NPR Date:
[17] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19. NPR Date Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by STARKE MEMORIAL HOSPITAL (15-0102) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

SIC	GNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	R CHECKBOX	ELECTRONI C SI GNATURE STATEMENT	
1	·		I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2 Si	gnatory Printed Name			2
3 Si	gnatory Title			3
4 Da	ate			4

			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	50, 651	49, 459	0	0	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swing Bed - NF	0				0	6. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11. 00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
12.00	CMHC I	0		0		0	12.00
200.0	0 Total	0	50, 651	49, 459	0	0	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.

Health Financial Systems STARKE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0102 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/30/2022 10:09 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 102 EAST CULVER RD 1.00 PO Box: 1.00 State: IN 2.00 City: KNOX Zip Code: 46534 County: STARKE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal STARKE MEMORIAL 150102 99915 07/11/1966 Ν 3.00 HOSPI TAI Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF Р STARKE MEMORIAL 15U102 99915 Р l03/01/2020l N 7 00 7.00 HOSPI TAI 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital - Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospital - Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2021 12/31/2021 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this Υ 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care 22.02 Ν Ν payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν Ν 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 Ν Ν N rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23 00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

	HMO paid and eligible but unpaid days in column 5.					
	inio para ana errgibre para anpara days in coranii c.	Urban/Rur	al S	Date of	Geogr	
		1.00		2. (1
6. 00	Enter your standard geographic classification (not wage) status at the beginning of the		2			26. C
	cost reporting period. Enter "1" for urban or "2" for rural.					
7. 00	Enter your standard geographic classification (not wage) status at the end of the cost		2			27. C
	reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable,					
- 00	enter the effective date of the geographic reclassification in column 2.					05.6
5. 00	If this is a sole community hospital (SCH), enter the number of periods SCH status in		0			35.0
	effect in the cost reporting period.	Begi nni	na:	Endi	na.	
		1. 00		2. (1
5. 00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number	1.00		2. (30	36.0
	of periods in excess of one and enter subsequent dates.					
7. 00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status		1			37.0
	is in effect in the cost reporting period.					
7. 01	Is this hospital a former MDH that is eligible for the MDH transitional payment in					37.0
	accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see					
	instructions)					
3. 00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is	01/01/2	021	12/31/	/2021	38.0
	greater than 1, subscript this line for the number of periods in excess of one and					
	enter subsequent dates.	Y/N		Υ/	NI	
		1.00		2. (+
00	Does this facility qualify for the inpatient hospital payment adjustment for low volume	1.00 Y		Y		39. (
. 00	hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column			'		37.
	1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in					
	accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes					
	or "N" for no. (see instructions)					
0. 00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or	N		N		40.0
	"N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for					
	no in column 2, for discharges on or after October 1. (see instructions)	<u> </u>		1		_
			V 1.00	2. 00	XI X 3. 00	-
	Prospective Payment System (PPS)-Capital		1.00	2.00	3.00	_
00	Does this facility qualify and receive Capital payment for disproportionate share in acc	ordance	l N	T N	l N	45. (
. 00	with 42 CFR Section §412.320? (see instructions)	or durice	"	'`	'`	10.
. 00	Is this facility eligible for additional payment exception for extraordinary circumstance	ces	N	l N	N	46.0
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I t					
	Pt. 111.	· ·				
. 00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for		N	N	N	47.0
. 00			N	N	N	48. (
	Teachi ng Hospi tal s					1
. 00			N			56.
	"N" for no in column 1 Lor column 2 if the reconnecto column 1 ic "V" or if this has					
	"N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hos					
	was involved in training residents in approved GME programs in the prior year or penulti					
	was involved in training residents in approved GME programs in the prior year or penulti year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment red					
00	was involved in training residents in approved GME programs in the prior year or penulti year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment red Enter "Y" for yes; otherwise, enter "N" for no in column 2.	lucti on?				57
. 00	was involved in training residents in approved GME programs in the prior year or penulti year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment red Enter "Y" for yes; otherwise, enter "N" for no in column 2. If line 56 is yes, is this the first cost reporting period during which residents in app	luction? proved				57.
. 00	was involved in training residents in approved GME programs in the prior year or penulti year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment red Enter "Y" for yes; otherwise, enter "N" for no in column 2. If line 56 is yes, is this the first cost reporting period during which residents in app GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If	duction? proved column 1				57.
. 00	was involved in training residents in approved GME programs in the prior year or penulti year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment red Enter "Y" for yes; otherwise, enter "N" for no in column 2. If line 56 is yes, is this the first cost reporting period during which residents in app	duction? proved column 1 Enter "Y"				57.
	was involved in training residents in approved GME programs in the prior year or penulti year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment red Enter "Y" for yes; otherwise, enter "N" for no in column 2. If line 56 is yes, is this the first cost reporting period during which residents in app GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If is "Y" did residents start training in the first month of this cost reporting period? E for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If colum "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	duction? proved column 1 Enter "Y" nn 2 is				57.
	was involved in training residents in approved GME programs in the prior year or penulti year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment red Enter "Y" for yes; otherwise, enter "N" for no in column 2. If line 56 is yes, is this the first cost reporting period during which residents in app GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If is "Y" did residents start training in the first month of this cost reporting period? E for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If colum "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. If line 56 is yes, did this facility elect cost reimbursement for physicians' services as	duction? proved column 1 Enter "Y" nn 2 is				
	was involved in training residents in approved GME programs in the prior year or penulti year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment red Enter "Y" for yes; otherwise, enter "N" for no in column 2. If line 56 is yes, is this the first cost reporting period during which residents in app GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If is "Y" did residents start training in the first month of this cost reporting period? E for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If colum "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	duction? proved column 1 Enter "Y" nn 2 is	N			57. (58. (

resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/30/2022 10:09 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 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) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 66.00 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 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) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CO	CN: 15-0102	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-Part I Date/Time Pro 5/30/2022 10	epared:
				1.00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.			ng period? Enter	N N	80. 00 81. 00
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00
3413.40(1)(1)(11)? Effet Y for yes and N for no. 18 this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified (under sectio	n	N	87. 00
11000(d)(1)(b)(v1): Enter 1 101 yes 61 N 101 110.			V 1. 00	XI X 2. 00	
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital	servi ces? Fi	nter "V" for	N	Y	90.00
yes or "N" for no in the applicable column.					
V1.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the appliance.			N	Y	91.00
12.00 Are title XIX NF patients occupying title XVIII SNF beds (dualinstructions) Enter "Y" for yes or "N" for no in the applications.		on)? (see		N	92.00
3.00 Does this facility operate an ICF/IID facility for purposes of		d XIX? Enter	N	N	93. 00
"Y" for yes or "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a	and "N" for no	o in the	N	N	94. 0
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the appl 16.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			0. 00 N	0. 00 N	95. 0 96. 0
applicable column. 17.00 If line 96 is "Y", enter the reduction percentage in the appl 8.00 Does title V or XIX follow Medicare (title XVIII) for the instepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for	terns and resi	dents post	O. 00 N	0. 00 Y	97. 0 98. 0
column 1 for title V, and in column 2 for title XIX. 18.01 Does title V or XIX follow Medicare (title XVIII) for the report of the column 1 for time of the column 2 for title XIX.				Y	98. 0
title XIX. 8.02 Does title V or XIX follow Medicare (title XVIII) for the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on			N	Y	98. 0
for title V, and in column 2 for title XIX. 8.03 Does title V or XIX follow Medicare (title XVIII) for a critireimbursed 101% of inpatient services cost? Enter "Y" for yes				N	98. 0
for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH I outpatient services cost? Enter "Y" for yes or "N" for no in			N d	N	98. 0
in column 2 for title XIX. 8.05 Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co				Y	98. 0
column 2 for title XIX. 8.06 Does title V or XIX follow Medicare (title XVIII) when cost in Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			N	Y	98. 0
Rural Providers 05.00 Does this hospital qualify as a CAH?			N		105. 0
06.00 If this facility qualifies as a CAH, has it elected the all-i	nclusive met	nod of payme			106. 0
for outpatient services? (see instructions) 07.00 Column 1: If line 105 is Y, is this facility eligible for costraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do y	1. (see ins	tructions)			107. 00
approved medical education program in the CAH's excluded IPF Enter "Y" for yes or "N" for no in column 2. (see instruction 08.00 sthis a rural hospital qualifying for an exception to the	ons)		2 N		108. 0
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati on	al Speech	Respi ratory	
	1.00	2.00	3.00	4.00	1
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
p. 5. 755 of in the for each therapy.				1.00	
				1.00	

	1. 00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A	N	110. 00
Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes,		
complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as		
appl i cabl e.		

are claimed, enter in column 2 the home office chain number. (see instructions)

Health Financial Systems STARKE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0102 Peri od: Worksheet S-2 From 01/01/2021 Part I 12/31/2021 Date/Time Prepared: To 5/30/2022 10:09 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: CHS/COMMUNITY HEALTH SYSTEMS, Contractor's Name: WPS Contractor's Number: 52280 141 00 LNC 142.00 Street: 4000 MERIDIAN BOULEVARD PO Box: 142.00 143.00 Ci ty: FRANKLIN State: TN Zip Code: 37067 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 1.00 2.00 $145.00\,|$ f costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Ν 146, 00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147.00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1 00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν Ν Ν N 155. 00 156.00 Subprovi der - IPF Ν 156. 00 Ν Ν Ν 157.00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν Ν 161.00 161. 10 CORF N 161. 10 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. CBSA Zip Code FTE/Campus Name County State 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)

167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167. 00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), reasonable cost incurred for the HIT assets (see instructions)	enter the		168. 00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	hardshi p		168. 01
169.00 f this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N transition factor. (see instructions)	"), enter the	9.9	99169. 00
	Begi nni ng	Endi ng	
	1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170. 00
	1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0 171. 00

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

1.00

	n Financial Systems STARKE MEMORI <i>I</i> TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-0102	Period:	w of Form CMS Worksheet S-	
0311	THE THE HEALTH SAIL RETINDONSEMENT GOEST CHINAT RE	rrovider	JON. 13 0102	From 01/01/2021 To 12/31/2021	Part II	epared
				Y/N	Date	. 09 all
		6 11 110		1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	TOT ALL NO TO	esponses. Ento	er all dates in t	rne	
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the			N		1. (
	reporting period? If yes, enter the date of the change in co	olumn 2. (see	instructions Y/N) Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare P		N			2. (
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	n 3, "V" for				
. 00	Is the provider involved in business transactions, including	a management	Y			3. (
	contracts, with individuals or entities (e.g., chain home o	ffices, drug				
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of directors through ownership, control, or family and othe					
	relationships? (see instructions)					
			Y/N	Type	Date	_
	Financial Data and Reports		1.00	2. 00	3. 00	
00	Column 1: Were the financial statements prepared by a Cert	ified Public	Y	A		4.0
	Accountant? Column 2: If yes, enter "A" for Audited, "C" for					
	or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	ilable in				
. 00	Are the cost report total expenses and total revenues diffe	rent from	N			5. (
	those on the filed financial statements? If yes, submit rec					
				Y/N 1. 00	Legal Oper. 2.00	-
	Approved Educational Activities			1.00	2.00	
00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, i	s the provide	r N		6.0
00	is the legal operator of the program?			N		, ,
. 00	Are costs claimed for Allied Health Programs? If "Y" see in: Were nursing programs and/or allied health programs approve		wed during th	e N		7. (8. (
	cost reporting period? If yes, see instructions.	a ana, or rone				
. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. (
0. 00	program in the current cost report? If yes, see instruction. Was an approved Intern and Resident GME program initiated o		the current	N		10. (
0. 00	cost reporting period? If yes, see instructions.					
1. 00	Are GME cost directly assigned to cost centers other than I	& R in an Ap	proved	N		11. (
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					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			net reporting	Y N	12. (13. (
3. 00	period? If yes, submit copy.	orrey change	during this c	ost reporting	IN	13. (
4. 00	If line 12 is yes, were patient deductibles and/or co-payme	nts waived? I	fyes, see in	structions.	N	14. (
5 00	Bed Complement Did total beds available change from the prior cost reportion	ng poriod2 lf	vos socins	tructions	Y	15. (
3. 00	bid total beds avairable change from the pirol cost reporti		rt A		t B	13. (
		Y/N	Date	Y/N	Date	
	DCOD Data	1. 00	2. 00	3. 00	4. 00	
	PS&R Data Was the cost report prepared using the PS&R Report only?	Y	05/19/2022	Υ	05/19/2022	16. (
5. 00	If either column 1 or 3 is yes, enter the paid-through					
5. 00						
5. 00	date of the PS&R Report used in columns 2 and 4 .(see			N		17. (
	date of the PS&R Report used in columns 2 and 4 (see instructions)	N				'''
	date of the PS&R Report used in columns 2 and 4 (see instructions)	N				
	date of the PS&R Report used in columns 2 and 4 (see 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	N				
7. 00	date of the PS&R Report used in columns 2 and 4 (see 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 in columns 2 and 4 (see instructions)			N		1Ω
7. 00	date of the PS&R Report used in columns 2 and 4 (see 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 in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N N		N		18.
7. 00	date of the PS&R Report used in columns 2 and 4 (see 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 in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this			N		18. (
	date of the PS&R Report used in columns 2 and 4 (see 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 in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N				18. (
7. 00	date of the PS&R Report used in columns 2 and 4 (see 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 in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N N		18.

	Financial Systems STARKE MEMORIA				u of Form CMS-	
HOSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pro 5/30/2022 10:	epared:
		Descri	pti on	Y/N	Y/N	
		()	1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
	The post of data for other posts for the other day actualities	Y/N	Date	Y/N	Date	
1 00	Was the east report propored only using the provider's	1. 00	2.00	3.00	4. 00	21 0
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEP	T CHILDRENS H	OSPI TALS)		1.00	
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 0
3. 00	Have changes occurred in the Medicare depreciation expense d reporting period? If yes, see instructions.	lue to apprais	als made dur	ing the cost	N	23. 0
24. 00	Were new leases and/or amendments to existing leases entered If yes, see instructions	linto during	this cost re	porting period?	N	24. 0
25. 00	Have there been new capitalized leases entered into during t	he cost repor	ting period?	'If yes, see	N	25. 0
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	cost reporti	ng period? I	f yes, see	N	26. 0
27. 00	instructions. Has the provider's capitalization policy changed during the	cost reportin	a period2 lf	Vas submit	N	27. 0
27.00	сору.		g period: 11	yes, sabiii t		
28. 00	<pre>Interest Expense Were new loans, mortgage agreements or letters of credit ent</pre>	ered into dur	ing the cost	reporti ng	N	28. 0
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or b	ond funds (De	bt Service R	eserve Fund)	N	29. 0
80. 00	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled matur	ictions	dobt2 lf voc	. 500	N	30.0
	instructions.					
31. 00	Has debt been recalled before scheduled maturity without iss instructions.	suance of new	debt? If yes	, see	N	31.0
2. 00	Purchased Services Have changes or new agreements occurred in patient care serv	ri ces furni she	d through co	ntractual	N	32. 0
33. 00	arrangements with suppliers of services? If yes, see instruction of the services of Sec. 2135.2 applications applied to the services of Sec. 2135.2 applications are services.	tions.	-		N	33. 0
33. 00	no, see instructions.		g to competi	tive bruding: 11	IV.	_ 33.0
34. 00	Provider-Based Physicians Are services furnished at the provider facility under an arr	angement with	nrovi der_ha	sed physicians?	Y	34.0
	If yes, see instructions.	9	•	. 3		
35. 00	If line 34 is yes, were there new agreements or amended exis physicians during the cost reporting period? If yes, see ins		ts with the	provi der-based	N	35.0
				Y/N	Date	
	Home Office Costs			1. 00	2. 00	
36. 00	Were home office costs claimed on the cost report?			Υ		36.0
	If line 36 is yes, has a home office cost statement been pre	pared by the	home office?			37. 0
8. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi				12/31/2020	38. 0
	the provider? If yes, enter in column 2 the fiscal year end	of the home o	ffi ce.		12,01,2020	
9. 00	If line 36 is yes, did the provider render services to other see instructions.	cnain compon	ents? If yes	i, N		39. 0
0. 00	If line 36 is yes, did the provider render services to the hinstructions.	ome office?	If yes, see	N		40. 0
		1.	00	2	00	
	Cost Report Preparer Contact Information	1.		Ζ.		
1. 00		I CHAEL		TEA		41.00
	respecti vel y.	OMMUNITY HEAL	TH CVCTEMC			42. 0
2 00						-ıı 4∠. U'
12. 00 13. 00	preparer.	15-628-6555	III SISILWS	MI CHAEL_TEA@CH:		43.0

Heal th	Financial Systems STARKE MEMOR	IAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0102	Peri od: From 01/01/2021	Worksheet S-2 Part II	
			To 12/31/2021	Date/Time Pre 5/30/2022 10:	pared: 09 am
		3.00			
	Cost Report Preparer Contact Information	3.00			
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SR MANAGER - REV MGT			41. 00
42.00	Enter the employer/company name of the cost report				42. 00
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43. 00

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part | | To 12/31/2021 | Date/Time Prepared:
 Heal th Financial
 Systems
 STARKE

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 15-0102

Component Worksheet A No. of Beds Bed Days CAH Hours Title V	To 12/31/2021 Date/Time Prepared: 5/30/2022 10:09 am	То				
Component Worksheet A No. of Beds Bed Days Available A						
Worksheet A Line Number No. of Beds Bed Days Available						
Line Number Available 1.00 2.00 3.00 4.00 5.00		Bed Days	No. of Beds	Worksheet A	Component	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 31.00 1 365 0.00 0 8.00 9.00 CORONARY CARE UNIT						
8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 31.00 1 365 0.00 0 8.00 9.00 CORONARY CARE UNIT	3.00 4.00 5.00	3.00	2.00	1.00		
Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 31.00 1 365 0.00 0 8.00 9.00 CORONARY CARE UNIT	5, 110 0.00 0 1.00	5, 110	14	30.00		1.00
for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 4.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 31.00 1 365 0.00 0 8.00						
2.00 HMO and other (see instructions) 3.00 HMO IPF Subprovider 4.00 HMO IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 31.00 1 365 0.00 0 8.00 9.00 CORONARY CARE UNIT						
3.00 HM0 I PF Subprovi der 4.00 HM0 I RF Subprovi der 5.00 Hospi tal Adults & Peds. Swing Bed SNF 6.00 Hospi tal Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 31.00 1 365 0.00 0 8.00 9.00 CORONARY CARE UNIT						
4.00 HM0 I RF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 31.00 1 365 0.00 0 8.00 9.00 CORONARY CARE UNIT					, , , , , , , , , , , , , , , , , , , ,	
5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 31.00 1 365 0.00 0 8.00 9.00					•	
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 31.00 1 365 0.00 0 8.00 9.00					•	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 31.00 1 365 0.00 0 8.00 9.00					1 '	
beds) (see instructions) 8.00 INTENSIVE CARE UNIT 31.00 1 365 0.00 0 8.00 9.00 CORONARY CARE UNIT 9.00					, ,	
8.00 INTENSIVE CARE UNIT 31.00 1 365 0.00 0 8.00 9.00 CORONARY CARE UNIT 9.00	5, 110 0.00 0 7.00	5, 110	14			7. 00
9. 00 CORONARY CARE UNIT 9. 00	0.00	0.45	4	04.00		0.00
	1 1	365	'	31.00		
TO. OU BURN INTENSIVE CARE UNIT						
44 OO CUDOLON INTENCIVE OADE UNIT						
11. 00 SURGI CAL INTENSIVE CARE UNIT						
12. 00 OTHER SPECIAL CARE (SPECIFY)				42.00	` ,	
13. 00 NURSERY		F 475	1.5	43.00		
14.00 Total (see instructions) 15 5,475 0.00 0 14.00		5, 4/5	15			
15. 00 CAH vi si ts 0 15. 00 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				40.00		
16. 00 SUBPROVI DER - I PF 40. 00 0 0 16. 00 17. 00 SUBPROVI DER - I RE 41. 00 0 0 17. 00	1 -1 -1 -1	-	0			
111 00 0051 NOT 5EK 1111	1 9 1 5	١	٩	41.00		
18.00 SUBPROVI DER 19.00 SKILLED NURSING FACILITY 19.00						
20. 00 NURSING FACILITY 20. 00						
20.00 NORSTNG PACIETY 20.00 21.00 OTHER LONG TERM CARE						
22. 00 HOME HEALTH AGENCY 101. 00 0 22. 00		•		101 00		
23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 115. 00 23. 00		•				
24. 00 H0SPI CE 116. 00 0 0 24. 00			0		` ′	
24. 10 HOSPICE (non-distinct part) 30.00 24.10	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1	J			
25. 00 CMHC - CMHC 99. 00 0 25. 00						
25. 10 CMHC - CORF 99. 10 0 25. 10						
26. 00 RURAL HEALTH CLINIC 88. 00 0 26. 00						
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 0 26. 25						
27.00 Total (sum of lines 14-26) 15 27.00			15			
28.00 Observation Bed Days					,	
29. 00 Ambul ance Trips 29. 00					,	
30.00 Employee discount days (see instruction)					·	
31.00 Employee discount days - IRF						
32.00 Labor & delivery days (see instructions) 0 0 32.00		0	o			
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				33.01 LTCH site neutral days and discharges	33. 01

 Heal th Financial
 Systems
 STARKE

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0102

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: | 5/30/2022 10: 09 am

						5/30/2022 10:	09 am_
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	674	32	1, 785			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)	617	220				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO I RF Subprovi der	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	. 7.4	0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation	674	32	1, 785			7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	0	0	0			8. 00
9. 00		U	٥	U			9. 00
10.00	CORONARY CARE UNIT 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		0	0			13. 00
14. 00	Total (see instructions)	674	32	1, 785	0.00	107. 48	14. 00
15. 00	CAH visits	0/4	0	1, 703		107.40	15. 00
16. 00	SUBPROVI DER - I PF	0	Ö	0		0.00	16. 00
17. 00	SUBPROVI DER – I RF	0	0	0		0.00	17. 00
18. 00	SUBPROVI DER	, i	Ĭ	· ·	0.00	0.00	18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0	o	0	0.00	0.00	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	0.00	23. 00
24.00	HOSPI CE	0	o	0	0.00	0.00	24. 00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25.00	CMHC - CMHC	0	O	0	0.00	0.00	25. 00
25. 10	CMHC - CORF	0	O	0	0.00	0.00	25. 10
26.00	RURAL HEALTH CLINIC	0	o	0	0.00	0.00	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	o	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	107. 48	27. 00
28. 00	Observation Bed Days		0	233			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			3			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

Provi der CCN: 15-0102

				To	12/31/2021	Date/Time Prep 5/30/2022 10:0	
		Full Time Equivalents	<u> </u>	Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	198	86	512	1. 00
2.00	HMO and other (see instructions)			150	o		2. 00
3.00	HMO IPF Subprovider				О		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0.00
8.00	INTENSIVE CARE UNIT						8. 00
9. 00 10. 00	CORONARY CARE UNIT						9. 00 10. 00
11. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	198	86	512	
15. 00	CAH visits						15. 00
16.00	SUBPROVIDER - IPF	0. 00	0	О	o	0	16.00
17.00	SUBPROVI DER - I RF	0. 00	0	0	o	0	17.00
18.00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0.00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00 24. 00
24. 00 24. 10	HOSPICE HOSPICE (non-distinct part)	0. 00					24. 00
25. 00	CMHC - CMHC	0. 00					25. 00
25. 10	CMHC - CORF	0.00					25. 10
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28.00	Observation Bed Days						28.00
29. 00	Ambul ance Tri ps						29.00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days LTCH site neutral days and discharges			0			33. 00 33. 01
33. UI	LIGHT SI LE HEULT AT MAYS AND UT SCHAFGES	I		ı V	I	ı	33. UI

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0102

					T	0 12/31/2021	Date/Time Pre 5/30/2022 10:	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	37 dill
		Number	Reported	on of Salaries (from Wkst.	Sal ari es (col . 2 ± col .	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				A-6)	3)	col . 4	COI. 3)	
	PART II - WAGE DATA	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	SALARI ES							
1.00	Total salaries (see	200. 00	6, 909, 972	0	6, 909, 972	223, 568. 00	30. 91	1. 00
2. 00	instructions) Non-physician anesthetist Part		C	0	0	0. 00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		C	0	0	0. 00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		C	0	0	0. 00	0. 00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		C	0	_	0. 00 0. 00	l .	1
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		C	0	0	0.00	0.00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	C	0	0	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		C	0	0	0. 00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		C	0	0	0. 00	0. 00	8. 00
9.00	SNF	44. 00	C	1	0	0.00	l .	
10. 00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS			0	0	0. 00	0. 00	10.00
11. 00	Contract labor: Direct Patient Care		73, 681	0	73, 681	594.00	124. 04	11. 00
12. 00	Contract labor: Top level management and other management and administrative services		C	0	0	0. 00	0. 00	12. 00
13. 00	Contract Labor: Physician-Part A - Administrative		37, 000	0	37, 000	220. 00	168. 18	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		C	0	0	0.00	0.00	14. 00
14. 01	Home office salaries		490, 935	0	490, 935			14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		C	0	0	0. 00 0. 00		14. 02 15. 00
15.00	- Administrative					0.00	0.00	15.00
16. 00	Home office and Contract Physicians Part A - Teaching		C	0	0	0. 00	0.00	16. 00
16. 01	Home office Physicians Part A - Teaching		C	0	0	0. 00		16. 01
16. 02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		C	0	0	0.00	0.00	16. 02
17. 00	Wage-related costs (core) (see instructions)		1, 487, 881	0	1, 487, 881			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		C	0	0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		C	0	0			21. 00
22. 00	Physician Part A - Administrative		C	0	0			22. 00
	Physician Part A - Teaching		C	0	О			22. 01
23. 00 24. 00 25. 00	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		C C C	1	_			23. 00 24. 00 25. 00
25. 50	approved program) Home office wage-related		129, 362	2 0	129, 362			25. 50
25. 51	(core) Related organization		C	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		C	0	0			25. 52
	wage-related (core)						I]

Provider CCN: 15-0102

					T	o 12/31/2021	Date/Time Prep 5/30/2022 10:0	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
			·	(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4	,	
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00	Employee Benefits Department	4. 00	94, 798		94, 798	,		
27. 00	Administrative & General	5. 00	869, 283	-53, 783	815, 500	,		
28. 00	Administrative & General under		0	0	0	0.00	0. 00	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00		29. 00
30. 00	Operation of Plant	7. 00	428, 056	0	428, 056	i i		
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00		
32. 00	Housekeepi ng	9. 00	190, 889	l .	190, 889			
33. 00	Housekeeping under contract		55, 700	0	55, 700	1, 688. 00	33. 00	33. 00
	(see instructions)							
34. 00	Dietary	10. 00	191, 850	-163, 382	28, 468	,		34. 00
35. 00	Di etary under contract (see		0	0	0	0.00	0. 00	35. 00
	instructions)	44.00		440.000	4/0.000		40.04	
36. 00	Cafeteri a	11. 00	0	163, 382	163, 382	i i		36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00		37. 00
38. 00	Nursing Administration	13. 00	252, 858			6, 394. 00		
39. 00	Central Services and Supply	14. 00	79, 199	l .	79, 199	,		
40. 00	Pharmacy	15. 00	255, 199		255, 199	i i		
41. 00	Medical Records & Medical	16. 00	48, 369	0	48, 369	3, 005. 00	16. 10	41. 00
	Records Li brary			_			05.51	
42. 00	Soci al Servi ce	17. 00	48, 928	0	48, 928	i i		42. 00
43.00	Other General Service	18. 00	0	il 0] 0	0.00	0.00	43.00

Provider CCN: 15-0102

| Period: | Worksheet S-3 | From 01/01/2021 | Part III | To 12/31/2021 | Date/Time Prepared:

					1	0 12/31/2021	5/30/2022 10: 0	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number		on of Salaries	, ,		Wage (col. 4 ÷	
			·	(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2.00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		6, 965, 672	0	6, 965, 672	225, 256. 00	30. 92	1.00
	instructions)							
2.00	Excluded area salaries (see		0	0	0	0.00	0.00	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		6, 965, 672	0	6, 965, 672	225, 256. 00	30. 92	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		601, 616	0	601, 616	17, 864. 00	33. 68	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		1, 617, 243	0	1, 617, 243	0. 00	23. 22	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		9, 184, 531	0	9, 184, 531	243, 120. 00	37. 78	6. 00
7.00	Total overhead cost (see		2, 515, 129	0	2, 515, 129	103, 080. 00	24. 40	7. 00
	instructions)							

Health Financial Systems	STARKE MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0102	Peri od: Worksheet S-3 From 01/01/2021 Part IV

	To 12/31/2021	Date/Time Prep 5/30/2022 10:0	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	110, 404	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	751, 193	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	16, 474	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	3, 787	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	-86	12.00
13.00		13, 361	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	74, 679	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	407, 350	17. 00
18.00	Medicare Taxes - Employers Portion Only	95, 267	18. 00
19. 00	Unemployment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	15, 452	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))	0	21. 00
22. 00		0	22. 00
23. 00		0	23. 00
24. 00		1, 487, 881	24. 00
2 1. 00	Part B - Other than Core Related Cost	1, 407, 001	21.00
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	STARKE MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0102	Peri od: From 01/01/2021	

		Т	0 12/31/2021	Date/Time Pre 5/30/2022 10:	
	Cost Center Description		Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1. 00	Total facility's contract labor and benefit cost		0	1, 487, 881	1. 00
2.00	Hospi tal		0	1, 487, 881	2. 00
3.00	Subprovi der - I PF		0	0	3. 00
4.00	Subprovi der - I RF		0	0	4. 00
5.00	Subprovi der - (0ther)		0	0	5. 00
6. 00	Swing Beds - SNF		0	0	6. 00
7. 00	Swing Beds - NF		0	0	7. 00
8. 00	Hospi tal -Based SNF				8. 00
9. 00	Hospi tal -Based NF				9. 00
	Hospi tal -Based OLTC				10. 00
11. 00	Hospi tal -Based HHA		0	0	11. 00
12. 00	Separately Certified ASC		0	0	12. 00
	Hospi tal -Based Hospi ce		0	0	13. 00
	Hospital-Based Health Clinic RHC		0	0	14. 00
	Hospital-Based Health Clinic FQHC		0	0	15. 00
16. 00	Hospi tal -Based-CMHC		0	0	16. 00
16. 10	Hospi tal -Based-CMHC 10		0	0	16. 10
	Renal Dialysis		0	0	17. 00
18. 00	Other		0	0	18. 00

1.00 Cost to charge ratio (W Medicaid (see instruction 1.00 Net revenue from Medican 1.00 Did you receive DSH or 1.00 If line 3 is yes, does 1.00 Medicaid charges 1.00 Medicaid cost (line 1 the 1.00 Difference between net 1.00 cost (line 1 the 1.00 Difference between net 1.00 version 1.00 Nedicaid cost (line 1 the 1.00 Difference between net 1.00 version 1.00 Nedicaid cost (line 1 the 1.00 Difference between net 1.00 version 1.00	ent care cost computation orksheet C, Part I line 202 colu ons for each line) d supplemental payments from Medic	Provider CC		Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prep 5/30/2022 10:0	pared:
Cost to charge ratio (W Medicaid (see instruction 2.00 Net revenue from Medica 3.00 Did you receive DSH or 4.00 If line 3 is yes, does 5.00 If line 4 is no, then e 6.00 Medicaid charges Medicaid cost (line 1 the 1.00 Difference between net 1.00 version v	orksheet C, Part I line 202 colu ons for each line) d supplemental payments from Medic	ımn 3 divided by li		To 12/31/2021	5/30/2022 10:0	
1.00 Cost to charge ratio (W Medicaid (see instruction 2.00 Net revenue from Medican 3.00 Did you receive DSH or 4.00 If line 3 is yes, does 1.00 Medicaid charges 7.00 Medicaid cost (line 1 the sum of the sum	orksheet C, Part I line 202 colu ons for each line) d supplemental payments from Medic	ımn 3 divided by li	ne 202 column		1.00	
1.00 Cost to charge ratio (W Medicaid (see instruction 2.00 Net revenue from Medican 3.00 Did you receive DSH or 4.00 If line 3 is yes, does 1.00 Medicaid charges 7.00 Medicaid cost (line 1 the sum of the sum	orksheet C, Part I line 202 colu ons for each line) d supplemental payments from Medic	ımn 3 divided by li	ne 202 column	->		
Medicaid (see instruction 2.00 Net revenue from Medica 3.00 Did you receive DSH or 4.00 If line 3 is yes, does 5.00 If line 4 is no, then e 6.00 Medicaid charges 7.00 Medicaid cost (line 1 t bifference between net < zero then enter zero)	ons for each line) d supplemental payments from Medic	umn 3 divided by li	ne 202 column			
2.00 Net revenue from Medica 3.00 Did you receive DSH or 4.00 If line 3 is yes, does 5.00 If line 4 is no, then e 6.00 Medicaid charges 7.00 Medicaid cost (line 1 t Difference between net < zero then enter zero)	d supplemental payments from Medic			8)	0. 184044	1.00
3.00 Did you receive DSH or 4.00 If line 3 is yes, does 5.00 If line 4 is no, then e 6.00 Medicaid charges 7.00 Medicaid cost (line 1 t 8.00 Difference between net < zero then enter zero)	supplemental payments from Medic				2 OE2 117	2.00
4.00 If line 3 is yes, does 5.00 If line 4 is no, then e 6.00 Medicaid charges 7.00 Medicaid cost (line 1 t 8.00 Difference between net < zero then enter zero)		ai d?			3, 953, 117 Y	3.00
5.00 If line 4 is no, then e 6.00 Medicaid charges 7.00 Medicaid cost (line 1 t 8.00 Difference between net < zero then enter zero)	ine 2 include all DSH and/or su		s from Medica	i d?	Ϋ́	4. 00
7.00 Medicaid cost (line 1 t B.00 Difference between net < zero then enter zero)	nter DSH and/or supplemental pay				0	5. 00
8.00 Difference between net < zero then enter zero)					21, 200, 400	
< zero then enter zero)		7	6 ! -	2 5 : 6	3, 901, 806	7.00
	revenue and costs for medicald p	rogram (line / min	us sum of line	3S 2 and 5; IT	0	8. 00
Children's Health Insura	nnce Program (CHIP) (see instruc	tions for each lin	e)			
9.00 Net revenue from stand-					0	9. 00
10.00 Stand-alone CHIP charge					0	
11.00 Stand-alone CHIP cost (· · · · · · · · · · · · · · · · · · ·	CUID (II: 11:	1! 0 !	6	0	
12.00 Difference between net enter zero)	revenue and costs for stand-alon	ie CHIP (IINE II MI	nus iine 9; ii	r < zero then	0	12. 00
	vernment indigent care program (see instructions for	or each line)			
	or local indigent care program ()	0	13.00
	vered under state or Local indig	jent care program (Not included	n lines 6 or	0	14. 00
10)	core program cost (line 1 times	lino 14)				15 00
	care program cost (line 1 times revenue and costs for state or l		nrogram (lin	e 15 minus line		
13; if < zero then ente		ocai margent care	program (TTM	, 10 11111103 11110	i I	10.00
Grants, donations and to instructions for each li	tal unreimbursed cost for Medic ne)	aid, CHIP and state	e/Local indige	ent care program	ns (see	
	ns, or endowment income restrict					17. 00
	opriations or transfers for supp			(oum of lines	0	
19.00 Total unreimbursed cost 8, 12 and 16)	for Medicaid , CHIP and state a	ind rocal indigent	care programs	(Sull of Titles	ا	19. 00
[5, 12 2112 12)			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col . 2)	
Uncomponented Caro (see	instructions for each line)		1.00	2. 00	3. 00	
	d uninsured discounts for the en	ntire facility	753, 14	2 0	753, 142	20. 00
(see instructions)						1
	ed for charity care and uninsure	ed discounts (see	138, 61	1 0	138, 611	21. 00
instructions)			00		020	22.00
22.00 Payments received from charity care	patients for amounts previously	written off as	93	0 0	930	22. 00
23.00 Cost of charity care (I	ne 21 minus line 22)		137, 68	1 0	137, 681	23. 00
•						
24 00 Dana tha amount and line	20			-6 -+ ! -! +	1.00	24.00
	20 column 2, include charges fo ered by Medicaid or other indige		ond a Length	of stay limit	N	24. 00
25.00 If line 24 is yes, ente	the charges for patient days b		care program	s length of	0	25. 00
Istav limit	for the entire hospital complex	(see instructions)			1, 770, 292	26. 00
stay limit 26.00 Total bad debt expense						
26.00 Total bad debt expense	ad debts for the entire hospital	complex (see inst	ructions)	İ	65, 717	1 21.00
26.00 Total bad debt expense27.00 Medicare reimbursable b27.01 Medicare allowable bad	debts for the entire hospital co				101, 103	27. 01
 26.00 Total bad debt expense 27.00 Medicare reimbursable b 27.01 Medicare allowable bad 28.00 Non-Medicare bad debt e 	debts for the entire hospital co kpense (see instructions)	omplex (see instruc	ctions)		101, 103 1, 669, 189	27. 01 28. 00
26.00 Total bad debt expense 27.00 Medicare reimbursable b 27.01 Medicare allowable bad 28.00 Non-Medicare bad debt e 29.00 Cost of non-Medicare an	debts for the entire hospital co	omplex (see instructed debt expense (see	ctions)		101, 103	27. 01 28. 00 29. 00

	Financial Systems	STARKE MEMORIAL				u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES	Provi der Co		Peri od:	Worksheet A	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	pared:
						5/30/2022 10:	
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(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		-116, 512	-116, 51	2 358, 749	242, 237	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		587, 672				2.00
3.00	00300 OTHER CAP REL COSTS		0	1	0 0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	94, 798	18, 302	113, 10	970, 437	1, 083, 537	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	869, 283	-269, 188	600, 09	5 -1, 311, 621	-711, 526	5. 00
7.00	00700 OPERATION OF PLANT	428, 056	865, 424	1, 293, 48	504, 330	1, 797, 810	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	63, 858	63, 85	8 0	63, 858	8. 00
9.00	00900 HOUSEKEEPI NG	190, 889	142, 797			332, 901	9. 00
10. 00	01000 DI ETARY	191, 850	144, 747	336, 59		36, 185	
11. 00	01100 CAFETERI A	0	0	0.0.15	0 298, 189	298, 189	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	252, 858	95, 297	1		401, 826	
14. 00 15. 00	O1400 CENTRAL SERVI CES & SUPPLY O1500 PHARMACY	79, 199	119, 663				1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	255, 199 48, 369	783, 700 102, 592			308, 677 150, 641	
17. 00	01700 SOCIAL SERVICE	48, 928	15, 574				
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	40, 720	13, 374	04, 30.	2 0	04, 302	17.00
30. 00	03000 ADULTS & PEDI ATRI CS	1, 015, 281	605, 525	1, 620, 80	6 -2, 829	1, 617, 977	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	0	1, 5_5, 55	0 0	0	31. 00
40.00	04000 SUBPROVI DER - I PF	O	0)	0	0	40. 00
41.00	04100 SUBPROVI DER - I RF	O	0)	0	0	41.00
43.00	04300 NURSERY	0	0		0	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	279, 076	161, 117	440, 19	3 -23, 566		1
51. 00	05100 RECOVERY ROOM	0	0	1	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	105.00	0	0	52.00
53. 00	05300 ANESTHESI OLOGY	520,040	185, 801	185, 80		183, 785	
54.00	05400 RADI OLOGY-DI AGNOSTI C	529, 948	364, 984				
54. 01 55. 00	05401 ULTRASOUND 05500 RADI OLOGY - THERAPEUTI C	62, 827	44, 490	107, 31	7 -17, 137	90, 180 0	54. 01 55. 00
56. 00	05600 RADI OLOGI - THERAPEUTI C	7, 954	53, 934	61, 88	8 -16, 856		56.00
57. 00	05700 CT SCAN	44, 619	111, 044	1		65, 026	1
58. 00	05800 MRI	22, 362	72, 464				1
59. 00	05900 CARDI AC CATHETERI ZATI ON	22, 302	72, 404	74, 02	0 00, 740	25,000	59.00
60. 00	06000 LABORATORY	527, 237	432, 650	959, 88	7 -58, 587	901, 300	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	,	0 0	0	62.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65.00	06500 RESPIRATORY THERAPY	329, 075	31, 588	360, 66	-1, 473	359, 190	65. 00
66.00	06600 PHYSI CAL THERAPY	348, 064	36, 068	384, 13	2 128, 220	512, 352	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	60, 509	5, 780			0	67. 00
68. 00	06800 SPEECH PATHOLOGY	53, 777	8, 154			0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	124, 014	15, 526	1		139, 540	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0 -51, 824	-51, 824	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0 42, 442		
74.00	07400 RENAL DIALYSIS		0		0 647, 369	647, 369 0	73. 00 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)		0		0	0	75.00
76. 00	03030 ANGI OCARDI OGRAPHY		0			0	76.00
. 5. 55	OUTPATIENT SERVICE COST CENTERS	<u> </u>		,	-, 0		1
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89. 00
90.00	09000 CLI NI C	854	162, 953	163, 80	7 -466	163, 341	90.00
91.00	09100 EMERGENCY	1, 044, 946	1, 860, 038	2, 904, 98	4 -901	2, 904, 083	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	1	0	0	94. 00
95. 00	09500 AMBULANCE SERVICES	0	0	1	0	0	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	
99. 00	09900	0	0		0	0	
	10000 I&R SERVICES-NOT APPRVD PRGM		0				100.00
	10100 HOME HEALTH AGENCY		0				100.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>			υ ₁	<u> </u>	1101.00
105 00	10500 KIDNEY ACQUISITION	O	0		0 0	n	105. 00
	10600 HEART ACQUISITION		n		0 0		106.00
	10700 LI VER ACQUI SI TI ON	o	0		o o		107. 00
	10800 LUNG ACQUISITION	O	0		0		108. 00
	10900 PANCREAS ACQUISITION	0	0		0		109. 00
	11000 INTESTINAL ACQUISITION	0	0		0 0		110. 00
111. 00	11100 ISLET ACQUISITION	0	0		0 0	0	111. 00

Health Financial Systems	STARKE MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO		Peri od:	Worksheet A	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/30/2022 10:	
Cost Center Description	Sal ari es	Other		Recl assi fi cati		
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00	0.00	0.00	4.00	col . 4)	
440 00 44000 LUTEREOT EVENUE	1.00	2.00	3. 00	4. 00	5. 00	110.00
113. 00 11300 INTEREST EXPENSE		0	1	0	l	113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0	1	0		114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	1	0		115. 00
116. 00 11600 H0SPI CE	0	0		0	l	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 909, 972	6, 706, 042	13, 616, 01	4 0	13, 616, 014	118. 00
NONREI MBURSABLE COST CENTERS			T			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1	0		190. 00
191. 00 19100 RESEARCH	0	0	(0		191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	-50, 292	-50, 29:	2 0	-50, 292	
193.00 19300 NONPALD WORKERS	0	0		0		193. 00
194.00 07950 SPECIALTY CLINICS / MOB	0	0	1	0	0	194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	6, 909, 972	6, 655, 750	13, 565, 72	2 0	13, 565, 722	200. 00

Provi der CCN: 15-0102

| Period: | Worksheet A | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: 5/30/2022 10:09 am

				10 12/31/2021	5/30/2022 10: 09 am
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7. 00		
C	GENERAL SERVICE COST CENTERS				
	00100 CAP REL COSTS-BLDG & FLXT	56, 204	298, 441		1. 00
	00200 CAP REL COSTS-MVBLE EQUIP	-198, 997	405, 821		2. 00
1	00300 OTHER CAP REL COSTS	0	0	•	3.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 083, 537	•	4. 00
	00500 ADMINISTRATIVE & GENERAL	4, 852, 257	4, 140, 731	•	5. 00
	00700 OPERATION OF PLANT	0	1, 797, 810	•	7. 00
	DO800 LAUNDRY & LINEN SERVICE	0	63, 858		8.00
	00900 HOUSEKEEPI NG	0	332, 901		9.00
	D1000 DI ETARY	0	36, 185	•	10.00
	D1100 CAFETERI A	-62, 979		1	11.00
	01300 NURSING ADMINISTRATION	-41, 400	360, 426	1	13. 00
1	01400 CENTRAL SERVICES & SUPPLY	0	188, 016	1	14.00
	D1500 PHARMACY	0	308, 677	1	15. 00
1	01600 MEDICAL RECORDS & LIBRARY	-766		•	16.00
	01700 SOCIAL SERVICE	0	64, 502		17. 00
	NPATIENT ROUTINE SERVICE COST CENTERS	427 725	1 101 252	ı	20.00
	03000 ADULTS & PEDIATRICS	-426, 625	1, 191, 352	1	30.00
	D3100 INTENSIVE CARE UNIT D4000 SUBPROVIDER - IPF	0	0		
	04100 SUBPROVIDER - IPF	0	0		40. 00 41. 00
	04300 NURSERY		0	1	43. 00
 	ANCILLARY SERVICE COST CENTERS	ı o	0		43.00
	D5000 OPERATING ROOM	O	416, 627		50.00
	D5100 RECOVERY ROOM		0	1	51.00
	D5200 DELIVERY ROOM & LABOR ROOM		0	•	52.00
	D5300 ANESTHESI OLOGY	-183, 333	452		53.00
	D5400 RADI OLOGY-DI AGNOSTI C	-17, 250	674, 793		54.00
	D5400 ULTRASOUND	17, 230	90, 180	•	54. 01
1	D5500 RADI OLOGY-THERAPEUTI C	0	0, 100	1	55. 00
1	D5600 RADI OI SOTOPE	0	45, 032		56. 00
	05700 CT SCAN	l o	65, 026	•	57. 00
	05800 MRI	o o	25, 880		58. 00
	D5900 CARDI AC CATHETERI ZATI ON	o o	0	1	59.00
	D6000 LABORATORY	0	901, 300	1	60.00
	D6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62. 00
	06400 I NTRAVENOUS THERAPY	0	0		64. 00
	06500 RESPIRATORY THERAPY	0	359, 190		65. 00
1	06600 PHYSI CAL THERAPY	l o	512, 352	•	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0.2,002	1	67. 00
	D6800 SPEECH PATHOLOGY	l o	0		68. 00
	06900 ELECTROCARDI OLOGY	l o	139, 540		69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0		70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	-13, 469	-65, 293		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	42, 442	•	72.00
	D7300 DRUGS CHARGED TO PATIENTS	-7, 969	639, 400		73.00
	07400 RENAL DIALYSIS	0	0	1	74.00
	D7500 ASC (NON-DISTINCT PART)	0	0		75. 00
	D3030 ANGI OCARDI OGRAPHY	O	0		76. 00
	DUTPATIENT SERVICE COST CENTERS	'			
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
90.00	09000 CLI NI C	-163, 341	0		90.00
91.00	09100 EMERGENCY	-1, 538, 816	1, 365, 267		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
C	OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DIALYSIS	0	0		94. 00
95.00	09500 AMBULANCE SERVICES	0	0		95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
99.00	09900 CMHC	0	0		99. 00
99. 10	09910 CORF	0	0		99. 10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0		100. 00
	10100 HOME HEALTH AGENCY	0	0		101. 00
	SPECIAL PURPOSE COST CENTERS				
	10500 KIDNEY ACQUISITION	0	0		105. 00
	10600 HEART ACQUISITION	0	0		106. 00
	10700 LIVER ACQUISITION	0	0		107. 00
	10800 LUNG ACQUISITION	o	0		108. 00
	10900 PANCREAS ACQUISITION	0	0		109. 00
110.00	11000 INTESTINAL ACQUISITION	0	0		110. 00
	11100 SLET ACQUISITION	0	0		111. 00
	11300 INTEREST EXPENSE	0	0	1	113. 00
114. 00	11400 UTILIZATION REVIEW-SNF	0	0		114. 00

Health Financial Systems

STARKE MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0102

From 01/01/2021
To 12/31/2021

Date/Time Prepared:

			10	12/31/2021	5/30/2022 1	
Cost Center Description	Adjustments	Net Expenses	<u> </u>			
	(See A-8)	For Allocation				
	6.00	7. 00				
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0				115. 00
116. 00 11600 H0SPI CE	0	0				116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 253, 516	15, 869, 530				118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
191. 00 19100 RESEARCH	0	0				191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	50, 292	0				192. 00
193. 00 19300 NONPALD WORKERS	0	0				193. 00
194.00 07950 SPECIALTY CLINICS / MOB	0	0				194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	2, 303, 808	15, 869, 530				200. 00

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-6
From 01/01/2021
To 12/31/2021 Date/Time Prepared: 5/30/2022 10:09 am Provider CCN: 15-0102

					10	12/31/2021	5/30/2022 10:09 am
		Increases			<u>.</u>		
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
	A - EMPLOYEE BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT		•	97 <u>0, 4</u> 37			1. 00
	0		0	970, 437			
1 00	B - RENTAL & LEASE EXPENSES	1 00	ام	100 740			1.00
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	182, 748			1.00
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP	2. 00 0. 00	0	16, 118 0			2.00
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	Ö	0			7. 00
8.00		0.00	o	0			8. 00
9. 00		0.00	o	0			9. 00
				198, 866			
	C - OTHER CAPITAL COSTS	<u> </u>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	66, 829			1. 00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	109, 172			2. 00
3.00	CAP REL COSTS-MVBLE EQUIP		0	1, 028			3. 00
	0		0	177, 029			
	D - REPAIRS/MAINTENANCE COST						
1.00	OPERATION OF PLANT	7. 00	0	515, 502			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 7. 00		0. 00 0. 00	0	0			6. 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	o	0			12. 00
13.00		0.00	O	0			13. 00
14.00		0.00	o	0			14. 00
15.00		0.00	O	0			15. 00
16.00		0.00	0	0			16. 00
18.00		0.00	0	0			18. 00
19. 00		0.00	•	0			19. 00
	0		0	515, 502			
4 00	E - NURSING SALARIES	40.00	E0 700				1.00
1. 00	NURSING ADMINISTRATION	13.00	<u>53, 7</u> 83 53, 783	<u>0</u>			1.00
	F - MEDICAL SUPPLIES		53, 783	U			
1.00	OPERATING ROOM	50.00	0	11, 397			1.00
2. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	3, 577			2. 00
2.00	PATI ENT	71.00	Ĭ	0,011			2.00
3.00	IMPL. DEV. CHARGED TO	72. 00	0	42, 442			3.00
	PATI ENTS			·			
	0			57, 416			
	G - COST OF DRUGS						
1.00	DRUGS CHARGED TO PATIENTS		0	647, 369			1. 00
	0		0	647, 369			
	H - PT, ST, AND OT						
1.00	PHYSI CAL THERAPY	66. 00	114, 286	13, 934			1. 00
2. 00				9			2. 00
	U DIFTADY COSTS		114, 286	13, 934			
1 00	I - DIETARY COSTS	11 00	1/2 202	124 007			1 00
1. 00	CAFETERI A	1100	16 <u>3, 3</u> 82 163, 382	13 <u>4, 8</u> 07 134, 807			1.00
500 00	Grand Total: Increases		331, 451	2, 715, 360			500.00
500.00	prana rotar. Thereases	I	221, 421	2, 113, 300			1 300. 00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2021 | To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: | 5/30/2022 10:09 am Provider CCN: 15-0102

						5/30/2022	10:09 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - EMPLOYEE BENEFITS				1		
1.00	ADMI NI STRATI VE & GENERAL	5.00	•	97 <u>0, 4</u> 37			1. 00
	0		0	970, 437			
	B - RENTAL & LEASE EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	86, 115			1.00
2.00	OPERATION OF PLANT	7.00	0	11, 172			2. 00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	5, 563			3.00
4.00	PHARMACY	15. 00	0	76, 895			4. 00
5.00	ADULTS & PEDIATRICS	30.00	0	2, 090			5. 00
6.00	RADI OI SOTOPE	56.00	0	150			6. 00
7.00	LABORATORY	60.00	0	15, 388			7. 00
8.00	RESPIRATORY THERAPY	65.00	0	1, 473			8. 00
9. 00	EMERGENCY	91.00		20			9. 00
	0		0	198, 866			
	C - OTHER CAPITAL COSTS			477.000	1 40		
1.00	ADMINISTRATIVE & GENERAL	5.00	0	177, 029			1.00
2.00		0.00	0	0			2. 00
3.00	<u> </u>	0.00		0	12		3. 00
	O DEBALBO MALNITENANOS COOT		0	177, 029			
	D - REPAIRS/MAINTENANCE COST			0.4.057			
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	24, 257			1.00
2.00	HOUSEKEEPI NG	9.00	0	785			2. 00
3.00	DIETARY	10.00	0	2, 223			3. 00
4.00	NURSING ADMINISTRATION	13. 00	0	112			4. 00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	3, 268			5. 00
6. 00	PHARMACY	15. 00	0	5, 958			6. 00
7. 00	MEDI CAL RECORDS & LI BRARY	16.00	0	320			7. 00
8. 00	ADULTS & PEDIATRICS	30.00	0	739			8. 00
9. 00	OPERATING ROOM	50.00	0	34, 963			9. 00
10.00	ANESTHESI OLOGY	53.00	0	2, 016			10.00
11. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	202, 889			11. 00
12. 00	ULTRASOUND	54. 01	0	17, 137			12. 00
13. 00	RADI OI SOTOPE	56.00	0	16, 706			13. 00
14.00	CT SCAN	57.00	0	90, 637			14. 00
15. 00	MRI	58.00	0	68, 946			15. 00
16. 00	LABORATORY	60.00	0	43, 199			16. 00
18. 00	CLINIC	90.00	0	466			18. 00
19. 00	EMERGENCY	91.00		881			19. 00
	0		0	515, 502			
	E - NURSING SALARIES						
1. 00	ADMI NI STRATI VE & GENERAL	5.00	<u>53, 7</u> 83	- — — ⁰ 0	0		1.00
	0		53, 783	0			
4 00	F - MEDICAL SUPPLIES	44.00		0.045			
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2, 015			1.00
2.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	55, 401	0		2. 00
0.00	PATI ENT	0.00					0.00
3.00		0.00		0	0		3. 00
	U COST OF BRUCE		0	57, 416			
1 00	G - COST OF DRUGS	15.00	ما	(47.2(0			1 00
1. 00	PHARMACY	15.00		64 <u>7, 3</u> 69			1. 00
	0		0	647, 369			
	H - PT, ST, AND OT	(7.00	(0.500	- 700	1		
1.00	OCCUPATI ONAL THERAPY	67.00	60, 509	5, 780			1.00
2.00	SPEECH PATHOLOGY	68.00	53,777	8, 154			2. 00
	U DI ETARY COSTS		114, 286	13, 934			
	I - DIETARY COSTS		.,				
1. 00	DI ETARY	10.00	163, 382	134, 807			1. 00
F00 07	U		163, 382	134, 807			F00 0-
500.00	Grand Total: Decreases		331, 451	2, 715, 360			500. 00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS STARKE MEMORIAL HOSPITAL Provider CCN: 15-0102

| Period: | Worksheet A-7 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared:

					To 12/31/2021	Date/Time Prep 5/30/2022 10:0	
				Acqui si ti ons		3/30/2022 10.	09 alli
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00	Land	142, 789	0		0 0	0	1. 00
2.00	Land Improvements	52, 134	0		0	0	2. 00
3.00	Buildings and Fixtures	1, 760, 186	0		0	0	3. 00
4.00	Building Improvements	4, 218, 941	0		0	0	4. 00
5.00	Fixed Equipment	1, 097, 772	0		0	0	5. 00
6.00	Movable Equipment	9, 390, 151	0		0	0	6. 00
7.00	HIT designated Assets	0	0		0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	16, 661, 973	0		0	0	8. 00
9.00	Reconciling Items	0	0		0	0	
10.00	Total (line 8 minus line 9)	16, 661, 973	0		0 0	0	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	DART 1 ANALYSIS OF SUMMORS IN SARITAL ASSET	6.00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		al				
1.00	Land	142, 789	0				1.00
2.00	Land Improvements	52, 134	0				2.00
3.00	Buildings and Fixtures	1, 760, 186	0			ļ	3.00
4.00	Building Improvements	4, 218, 941	0			ļ	4. 00
5.00	Fi xed Equipment	1, 097, 772	0				5. 00
6.00	Movable Equipment	9, 390, 151	0				6. 00
7.00	HIT designated Assets	1/ //1 070	U				7. 00
8. 00 9. 00	Subtotal (sum of lines 1-7)	16, 661, 973	0				8. 00 9. 00
	Reconciling Items	1/ //1 072	0			ļ	
10. 00	Total (line 8 minus line 9)	16, 661, 973	O			ļ	10.00

Не	al th	Financial Systems	STARKE MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RE	CONCI	LIATION OF CAPITAL COSTS CENTERS		Provi der CO	CN: 15-0102	Peri od:	Worksheet A-7	
						From 01/01/2021	Part II	
						To 12/31/2021	Date/Time Pre	
_							5/30/2022 10:	09 am
				SU	JMMARY OF CAP	I TAL		
		Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
						instructions)	instructions)	
			9. 00	10.00	11. 00	12.00	13. 00	
	F	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.		CAP REL COSTS-BLDG & FLXT	-116, 512	0		0 0	0	1.00
2.	00	CAP REL COSTS-MVBLE EQUIP	587, 672	0		0 0	0	2. 00
3.	00	Total (sum of lines 1-2)	471, 160	0		o o	0	3. 00
		,	SUMMARY OF	- CAPLTAL				
		Cost Center Description	Other I	Total (1) (sum				
		· ·	Capi tal -Relate	` , `				
			d Costs (see	through 14)				
			instructions)	tili odgir 14)				
			14. 00	15. 00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1	-		STILLT A, COLUMN					1 00
		CAP REL COSTS-BLDG & FIXT	0	-116, 512	1			1.00
		CAP REL COSTS-MVBLE EQUIP	0	587, 672	•			2. 00
2	\cap	Total (cum of lines 1 2)	· Δ	171 140	I			2 00

0 0 0

-116, 512 587, 672 471, 160

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FLX1
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Pre 5/30/2022 10:	pared:
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col . 2)	•		
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	NTERS					
1.00	CAP REL COSTS-BLDG & FLXT	7, 271, 822				0	
2.00	CAP REL COSTS-MVBLE EQUIP	9, 390, 151		7, 0,0, 10			
3.00	Total (sum of lines 1-2)	16, 661, 973		16, 661, 97			3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)	0.00	10.00	
	DART III DECONOLIIATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	INTERS	0	1	201, 992	0	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	0			0 404, 793		2.00
3.00	Total (sum of lines 1-2)		0		606, 785		3.00
0.00	Total (Sam of Titles 1 2)		SI	JMMARY OF CAPI			0.00
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11 00	12.00	12.00	instructions)	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	11.00	12.00	13. 00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	INTERS 0	-12, 723	109, 17:	2 0	298, 441	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0 0	405, 821	2.00
3.00	Total (sum of lines 1-2)	0			-		
		'		'	•		

Health Financial Systems STARKE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-0102 Peri od: Worksheet A-8 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/30/2022 10:09 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 4 00 0 00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay -14, 765 ADMI NI STRATI VE & GENERAL 7.00 В 5.00 7.00 stations excluded) (chapter 21) 8.00 Tel evi si on and radio servi ce В -722 CAP REL COSTS-MVBLE EQUIP 2.00 8.00 (chapter 21) Parking lot (chapter 21) 9.00 0.00 9.00 Provider-based physician -2, 329, 365 A-8-2 10.00 10.00 adj ustment ORADI OLOGY-DI AGNOSTI C 11.00 Sale of scrap, waste, etc. В 54.00 11.00 (chapter 23) Related organization 12.00 A-8-1 5, 075, 683 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests В -62, 979 CAFETERI A 11.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others 16.00 Sale of medical and surgical -13, 469 MEDI CAL SUPPLI ES CHARGED TO 71.00 16.00 В supplies to other than PATI FNT pati ents 17.00 Sale of drugs to other than В -7, 969 DRUGS CHARGED TO PATIENTS 73.00 17.00 pati ents -766 MEDICAL RECORDS & LIBRARY 18.00 Sale of medical records and В 16.00 18.00 abstracts Nursing and allied health 19 00 19 00 0 00 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 Income from imposition of 21.00 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24 00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review OUTILIZATION REVIEW-SNF 114.00 25.00 physicians' compensation (chapter 21) Depreciation - CAP REL 112, 913 CAP REL COSTS-BLDG & FIXT 26.00 В 1.00 26.00 COSTS-BLDG & FLXT Depreciation - CAP REL -248, 444 CAP REL COSTS-MVBLE EQUIP 27.00 В 2.00 27.00 COSTS-MVBLE EQUIP 28.00 0 *** Cost Center Deleted *** 19.00 28.00 Non-physician Anesthetist Physicians' assistant 29 00 29.00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30.99 OADULTS & PEDIATRICS 30.00 30.99 instructions)

OSPEECH PATHOLOGY

-41, 400 NURSING ADMINISTRATION

68.00

0.00

13.00

31.00

32.00

0 33.00

33.00 TRAINING REVENUE

Adjustment for speech

CAH HIT Adjustment for

Depreciation and Interest

pathology costs in excess of limitation (chapter 14)

A-8-3

В

31.00

32.00

From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

5/30/2022 1	. 09 am
Expense Classification on Worksheet A	
To/From Which the Amount is to be Adjusted	
Cost Contan Description Desig (Code (2)) Amount Cost Contan Line # What A 7 Des	
Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref	
1.00 2.00 3.00 4.00 5.00	00.01
	2 33. 01
33. 03 GRANT NCOME B -3, 685 ADMINI STRATI VE & GENERAL 5. 00	0 33. 03
33. 04 OTHER MISCELLANEOUS REVENUE B -6, 727 ADMINISTRATIVE & GENERAL 5.00	33. 04
33. 05 TELEPHONE DEPRECIATION EXPENSE B -557 CAP REL COSTS-MVBLE EQUIP 2.00	9 33. 05
33. 06 TELEVI SI ON EXPENSE B -13, 146 ADMINI STRATI VE & GENERAL 5.00	33.06
33. 07 CHARI TABLE CONTRI BUTI ONS A -4, 500 ADMI NI STRATI VE & GENERAL 5. 00	33. 07
33.08 MARKETING DEPARTMENT B -99,759 ADMINISTRATIVE & GENERAL 5.00	33.08
33. 09 CHARI TBABLE CONTRIBUTIONS 0 0.00	33. 09
33. 10 OTHER ADJUSTMENTS (SPECIFY) B 0 0.00	0 33. 10
(3)	
33. 11 ALLOCATED RENT EXPENSE B 50, 292 PHYSICIANS' PRIVATE OFFICES 192.00	33. 11
33.12 OTHER ADJUSTMENTS (SPECIFY) 0.00	33. 12
(3)	
33. 13 MEALS & EVENTS B -75 ADMINISTRATIVE & GENERAL 5.00	33. 13
33. 14 ASSOCIATION DUES B -7, 200 ADMINISTRATIVE & GENERAL 5. 00	33. 14
50.00 TOTAL (sum of lines 1 thru 49) 2,303,808	50.00
(Transfer to Worksheet A,	55.00
column 6, Line 200.)	

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

⁽¹⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0102 Peri od: Worksheet A-8-1 From 01/01/2021 To 12/31/2021 Date/Time Prepared: OFFICE COSTS

				10 12/31/2021	5/30/2022 10:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	0.00	l .		0	0	1. 00
2.00	0.00	l .		0	0	2. 00
3.00	0.00	l .		0	0	3. 00
4.00		CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	1, 093	0	4. 00
4. 01	l e	CAP REL COSTS-MVBLE EQUI P	PASI Capital Costs - Moveabl	134	0	4. 01
4.02		ADMINISTRATIVE & GENERAL	PASI Operating Costs	92, 798	· ·	4. 02
4.03	l e	ADMINISTRATIVE & GENERAL	Shared Service Center Alloca	453, 277		4. 03
4.04	1		New Capital - Building & Fix		0	4. 04
4.05		CAP REL COSTS-MVBLE EQUI P	New Capital - Movable Equipm		0	4. 05
4.06		ADMINISTRATIVE & GENERAL	Non-Capital Home Office Cost	544, 819		4. 06
4.07		ADMINISTRATIVE & GENERAL	Malpractice Costs	8, 290		
4.08		ADMINISTRATIVE & GENERAL	Interest Expense	0	-5, 015, 709	
4. 09		ADMINISTRATIVE & GENERAL	Management Fees	0	375, 866	
4. 10		ADMINISTRATIVE & GENERAL	401K Fees	0	4, 400	
4. 11		ADMINISTRATIVE & GENERAL	Audit Fees	0	10, 358	
4. 12		ADMINISTRATIVE & GENERAL	Corporate Overhead Allocatio	0	215, 408	
4. 13	II	ADMINISTRATIVE & GENERAL	HIIM Allocation	0	96, 893	4. 13
4.14	II.	ADMINISTRATIVE & GENERAL	Contract Management	0	26, 051	4. 14
4. 15		ADMINISTRATIVE & GENERAL	PASI Lien Unit Collection Fe	1 172 752	8, 153	
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to			1, 172, 753	-3, 902, 930	5. 00
	Worksheet A-8, column 2,					
	line 12.					
	JELLIC 12.					

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

1100 110	The best posted to normalize the amount of the partition and the strain of the partition partition partition partitions and the partition partitio						
				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 RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

6.00	В	0. 00 COMMUI NI TY HEAL 100. 0	6. 00
7.00	В	0.00 PASI 100.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.

 F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
	A. COSTS INCURI	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE COS	STS:		
1.00	0	9		1. 00
2.00	o	9		2. 00
3.00	o	0		3. 00
4.00	1, 093	9		4. 00
4. 01	134	9		4. 01
4.02	-29, 296	0		4. 02
4.03	321, 277	0		4. 03
4.04	21, 750	9		4. 04
4.05	50, 592	9		4. 05
4.06	544, 819	0		4. 06
4.07	-113, 266	0		4. 07
4.08	5, 015, 709	0		4. 08
4.09	-375, 866	0		4. 09
4. 10	-4, 400	0		4. 10
4. 11	-10, 358	0		4. 11
4. 12	-215, 408	0		4. 12
4. 13	-96, 893	0		4. 13
4. 14	-26, 051	0		4. 14
4. 15	-8, 153	0		4. 15
5.00	5, 075, 683			5. 00
* Tho	amounts on Line	oc 1 / (and sub	scripts as appropriate) are transferred in detail to Werkshoot A. column 6. Lines as	

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

Related Organization(s) and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	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 reimbursement under title XVIII.

6.00	HOSP COMPANY	6.00
7.00	COLLECTI ONS	7.00
8.00		8.00
9.00		9.00
10.00		10.00
10. 00 100. 00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

| Period: | Worksheet A-8-2 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0102

					-	Го 12/31/2021	Date/Time Pre 5/30/2022 10:	epared: 09 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	30. 00	AGGREGATE-ADULTS &	426, 625	426, 625	0	211, 500	0	1. 00
2. 00	0.00	PEDI ATRI CS	,		0	0	0	2. 00
3.00		AGGREGATE-ANESTHESI OLOGY	183, 333	183, 333		239, 400		3. 00
4. 00		AGGREGATE-RADI OLOGY-DI AGNOST	17, 250		_	271, 900		4. 00
1. 00	01.00	I C	17,200	17,200		271,700	Ĭ	1. 00
5.00	0.00		0	0	0	0	0	5.00
6.00	90.00	AGGREGATE-CLI NI C	163, 341	163, 341	0	179, 000	0	6.00
7.00		AGGREGATE-EMERGENCY	1, 538, 816	1, 538, 816	0	197, 500	0	7. 00
8.00	0. 00		0	0	0	0	0	8. 00
9.00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10.00
200.00	Wko+ Aline#	Coot Contan/Dhyaiaian	2, 329, 365		Cost of	Provi der	Dhysi si an Cast	200. 00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	Unadjusted RCE		Component	Physician Cost of Malpractice	
		r deliti i i ei	Limit	Li mi t	Continuing	Share of col.	Insurance	
					Education	12	11104141100	
	1. 00	2. 00	8. 00	9.00	12. 00	13.00	14.00	
1.00	30. 00	AGGREGATE-ADULTS &	0	0	0	0	0	1. 00
0.00		PEDI ATRI CS						0.00
2.00	0.00		0	0	-	0	1	2.00
3. 00 4. 00		AGGREGATE-ANESTHESI OLOGY AGGREGATE-RADI OLOGY-DI AGNOST	0	0	0	0	0	3. 00 4. 00
4.00	34.00	I C			0			4.00
5.00	0.00		0	0	0	0	o	5.00
6.00	90.00	AGGREGATE-CLI NI C	0	0	0	0	o	6.00
7.00		AGGREGATE-EMERGENCY	0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10.00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200. 00
	WKSt. A LINE #	I denti fi er	Component	Limit	Di sal I owance	Adjustillerit		
		I deliti i i ei	Share of col.		Di Sai i Owance			
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00	30. 00	AGGREGATE-ADULTS &	0	0	0	426, 625		1. 00
		PEDI ATRI CS						
2.00	0.00		0	0	_	0		2.00
3.00		AGGREGATE - ANESTHESI OLOGY AGGREGATE - RADI OLOGY - DI AGNOST	0	0	_	183, 333		3. 00 4. 00
4. 00	54.00	IC	U	l o	0	17, 250		4.00
5. 00	0.00		n	0	0	0		5. 00
6. 00		AGGREGATE-CLI NI C	٥	Ö	_	163, 341		6. 00
7. 00		AGGREGATE-EMERGENCY	Ö	ő		1, 538, 816		7. 00
8.00	0.00		0	0	0	0	1	8. 00
9.00	0. 00		0	0	0	0		9. 00
10. 00	0.00		0	0		0		10.00
200.00			0	0	0	2, 329, 365		200. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS STARKE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Worksheet B
Part I
Date/Time Prepared:
5/30/2022 10:09 am Provider CCN: 15-0102 Peri od: From 01/01/2021 To 12/31/2021 CAPITAL RELATED COSTS Net Expenses for Cost Cost Center Description BLDG & FIXT MVBLE EQUIP EMPLOYEE Subtotal BENEFITS

COURT 71			Allocation			DEPARTMENT		
CREERLAL SERVICE COST CENTERS			(from Wkst A col. 7)					
1.00		CENERAL SERVICE COST CENTERS	0	1. 00	2. 00	4. 00	4A	
2.00	1.00		298, 441	298, 441				1. 00
5 00 00000000000000000000000000000000								
7.00 0.00700 DOTRO DOTREATION OF PLANT 1,797, 810 69,002 93,827 0 1,900, 209 7,00 0 66,637 124,969 8.00 900 0,0000 INUSIX KEEP INFG 332,901 7,279 9,06 0 300,190 9,00 90,00 0 350,190 9,00 10000 INUSIX KEEP INFG 332,901 7,729 9,06 0 300,190 9,00 10000 INUSIX KEEP INFG 332,901 7,729 1,00 300,190 9,00 10000 INUSIX KEEP INFG 200,1000 INUSIX KEEP INFG <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>/ 210 OE1</td> <td></td>							/ 210 OE1	
8.00 00000 LAURDEN'S & LINEN SERVICE 63,858 0 0 0,66,637 132,495 8,00 10.00 10000 DIETARY 36,185 7,746 10.533 30,608 85,072 10.00 10.00 DIETARY 36,185 7,746 10.533 30,608 85,072 10.00 10.00 DIETARY 36,185 7,746 10.533 30,608 85,072 10.00 10.00 DIETARY 36,815 7,746 10.533 30,608 242,478 11.00 10.00 10.00 DIETARY 36,816 7,746 10.533 30,608 242,478 11.00 DIETARY 36,816 37,746 37,740								
10.00 010000 DETARY 36, 185 7, 74e 10.533 30, 608 85, 072 10.00 10.00 01500 MIRST NA AMMINISTRATION 360, 420 774 1, 324 26, 198 388, 922 13.00 10.00 10.00 01500 MIRST NA AMMINISTRATION 360, 420 774 1, 324 26, 198 388, 922 13.00 10.00 01500 MIRST NA AMMINISTRATION 360, 420 774 1, 324 26, 198 388, 922 13.00 16.00 01500 MIRST NA AMMINISTRATION 360, 420 777 41, 977 41, 979 248, 888 14.00 01400 MIRST NA PRINTED CS S SUPPLY 149, 975 2, 792 3, 797 40, 920 177, 384 16.00 10.00 01500 MIRST NA PRINTED CS S SUPPLY 149, 975 2, 792 3, 797 40, 920 177, 384 16.00 177, 750 172, 288 17.00 172, 288 17.00 172, 288 172, 288 172, 288 172, 288 172, 288 172, 288 172, 288 172, 288 172, 288 172, 288 172, 288 172, 288 172, 288 172, 288 172, 288 172, 288 172, 288 172, 288 172, 2	8.00	00800 LAUNDRY & LINEN SERVICE			0	68, 637		
11.00 01100 CAFETERIA 225, 210 2,111 2,871 4,565 244,757 11.00 13.00 13.00 01300 CARETRIA 300, 420 774 49,169 248,863 14.00 13.00 13.00 01300 CARRINAL SERVICES & SUPPLY 188,010 4,957 6,741 49,169 248,863 14.00 13.00 13.00 01300 CARRINAL SERVICES & SUPPLY 188,010 4,957 6,741 49,169 248,863 14.00 17.00 01500 CARRINAL SERVICES & SUPPLY 188,010 4,957 7,766 7		l l	1			-1	•	
13.00 01300 NURSI NC ADMINI STRATION 200, 42c 774 1.32 4 26, 198 388, 922 13.00			1					
15.00 01500 PHARMACY 308,677 3,888 4,677 12,690 329,371 15.00 10.00 10.00 10.00 10.00 10.00 17.00								
16-00 0 16-00 MEDICAL RECORDS & LIBRARY 149, 875 2, 790 3, 797 40, 920 197, 384 16-00 197, 00 170, 00								
17.00			1					
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31.00 0 3100 (INTENSIVE CARE UNIT			1 404 050	07.74		440 704	1 110 100	
40.00 04000 SUBPROVIDER - I FF			1, 191, 352	27, 746	37, 729	162, 796		
A3. 00 MINSERY MIN A3. 00 MINSERY A5. 00 MIN A5. 00 A5. 0			l o	0	ő	Ö	-	
MINISTRAY SERVICE COST CENTERS		1	O	0	0	o		
	43. 00		0	0	0	0	0	43.00
52.00 05200 DELIVERY BOOM & LABOR ROOM 0 0 0 0 52.00	50. 00		416, 627	30, 164	41, 017	44, 749	532, 557	50. 00
53.00 05300 ARESTHESI OLGGY 452 0 0 0 452 53.00			0	0	0	0		
54. 00 05400 RADIOLOGY-DIAGNOSTIC 674, 793 12, 807 17, 415 84, 975 789, 990 54, 00 55, 00 05500 RADIOLOGY-THERAPPUTIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			452	0	0	0		
55.00 OSSOO RADIO LOCY_THERAPEUTIC S. 00 O O O O O O O O O				12, 807	17, 415	84, 975		
56. 00 05600 050			90, 180	0	0	10, 074		
57.00 05700 CT SCAN 56.026 1,712 2,328 7,154 76.20 57.00 58.00 05800 MSI			45.022	0	0	0 1 275		
58.00 05800 MR 25,880 4,515 6,139 3,586 40,120 58.00			1	1, 712	2, 328			
60.00 0.0000 LABORATORY 901,300 6,997 9,515 84,540 1,002,352 60.00	58. 00	05800 MRI	1				40, 120	58. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 0 0 0			001 200	6 007	0 515	0		
64.00 06400 INTRAVERIOUS THERAPY 0 0 0 0 0 0 64.00		· ·	901, 300		l	0		
66.00 06600 PMSI CAL THERAPY 512,352 7,653 10,407 74,136 604,548 66.00			0	0	0	o	-	
67. 00 06700 05CUPATI ONAL THERAPY 0 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 139,540 1,569 2,134 19,885 163,128 69. 00 70. 00 07000 ELECTROCARDI OLOGY 139,540 1,569 2,134 19,885 163,128 69. 00 70. 00 07000 ELECTROCARDI OLOGY 139,540 1,569 2,134 19,885 163,128 69. 00 70. 00 07000 ELECTROCARDI OLOGY 139,540 0 0 0 0 0 0 71. 00 07100 MDI CAL SUPPLIES CHARGED TO PATI ENT -55,293 0 0 0 0 0 -55,293 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 42,442 0 0 0 0 42,442 72. 00 73. 00 07300 DRIGS CHARGED TO PATI ENTS 639,400 0 0 0 0 639,400 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 75. 00 07500 ASC (NON-DISTI NCT PART) 0 0 0 0 0 0 0 76. 00 07500 ASC (NON-DISTI NCT PART) 0 0 0 0 0 0 76. 00 07500 ASC (NON-DISTI NCT PART) 0 0 0 0 0 76. 00 07500 ASS (NON-DISTI NCT PART) 0 0 0 0 0 76. 00 07500 ASS (NON-DISTI NCT PART) 0 0 0 0 0 76. 00 07500 ASS (NON-DISTI NCT PART) 0 0 0 0 0 76. 00 07500 ASS (NON-DISTI NCT PART) 0 0 0 0 0 76. 00 07500 O7500 O7500 O7500 O7500 76. 00 07500 O7500 O7500 76. 00 07500 O7500 O7500 O7500 77. 00 07500 O7500 O7500 O7500 77. 00 07500 O7500 O7500 O7500 77. 0			1					
69-00 06900 ELECTROCARDIOLOGY 139,540 1,569 2,134 19,885 163,128 69.00			0		1			
70.00 07000 ELECTROENCEPHALGGRAPHY			0	0	0	0		
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT -65, 293 0 0 0 -65, 293 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 42, 442 0 0 0 0 42, 442 72. 00 0 0 0 0 0 0 0 0 0			139, 540	1, 569	2, 134	19, 885 0		
73. 00 07300 DRUGS CHARGED TO PATIENTS 639, 400 0 0 0 639, 400 74. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 76. 00 03030 ANGIOCARDI OGRAPHY 0 0 0 0 0 00 07500 08900 ORBORI CENTERS 88. 00 08900 RENAL HEALTH CLINIC 0 0 0 0 0 89. 00 09900 CLINIC 0 0 0 0 0 0 91. 00 09000 CLINIC 0 0 0 0 0 0 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 99. 00 09900 CORF 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 99. 10 100. 00 10000 LRY SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 101. 00 10100 LRY SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 101. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 101. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 101. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 106. 00 10500 LIVER ACQUI SI TI ON 0 0 0 0 107. 00 10700 LIVER ACQUI SI TI ON 0 0 0 0 107. 00 10700 LIVER ACQUI SI TI ON 0 0 0 0 107. 00 10700 LIVER ACQUI SI TI ON 0 0 0 0 107. 00 10700 LIVER ACQUI SI TI ON 0 0 0 0 107. 00 10700 LIVER ACQUI SI TI ON 0 0 0 0 107. 00 10700 LIVER ACQUI SI TI ON 0 0 0 0 107. 00 10700 LIVER ACQUI SI TI ON 0 0 0 0 107. 00 10700 LIVER ACQUI SI TI ON 0 0 0 0 107. 00 10700 LIVER ACQUI SI TI ON 0 0 0 0 107. 00 10700 LIVER ACQUI SI TI ON 0 0 0 0 108. 00 10700 10700 10700 10700 10700 10700 10700 10700 10700 10700 10700 10700 10700 10700	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	-65, 293	0	ő	Ö		
74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 0				0	0	o		
75. 00			639, 400	0	0	0		
Sal 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 88.00				0	o	o		
88. 00	76. 00		0	0	0	0	0	76. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 0 99. 00 90. 00 09900 CLINI C 0 0 0 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 1, 365, 267 14, 583 19, 830 167, 693 1, 567, 373 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 92. 00 071 FER REI MBURSABLE COST CENTERS 94. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 99. 00 99. 10 09900 CMRC 0 0 0 0 0 0 0 0 99. 10 100. 00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 0 100. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 101. 00 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 0 0 105. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 0 0 107. 00	88 00			0	O	ol	0	88 00
91. 00			Ö	0	Ö	Ö	-	
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 92. 00 0THER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 0 94. 00 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 95. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 0 97. 00 99. 00 09900 CMHC 0 0 0 0 0 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 0 99. 10 100. 00 100 100 12R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 101. 00 10100 HEALTH AGENCY 0 0 0 0 0 0 101. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 105. 00 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 107. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 107. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 107. 00 107			0	0	0	0		
94. 00			1, 365, 267	14, 583	19, 830	167, 693		
95. 00	72.00						0	72.00
96. 00		l l	0			0		
97. 00			0	0	0	0	-	
99. 10		l l		0	ő	Ö		
100. 00 10000 L&R SERVI CES-NOT APPRVD PRGM			O	0	0	o		
101.00		· ·	0	0	0	0		
105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105. 00 106. 00 106.00 106.00 0 0 0 0 0 106. 00 107. 00 107.00 LI VER ACQUI SI TI ON 0 0 0 0 0 0 0 107. 00		1	l o	0	Ö	Ö		
106. 00 10600 HEART ACQUISITION		SPECIAL PURPOSE COST CENTERS						405 00
107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 107. 00			0		1	0		
				0	O	ő	0	107. 00
108. 00 10800 LUNG ACQUISITION 0 0 0 108. 00			0		-	o		
109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109. 00	109.00	NI 10A00 LAWCKEY2 ACKNI 21 11 NM	l O	0	ı o	υĮ	0	109.00

Health Financial Systems	STARKE MEMORIAL HOSPITAL	In Lieu	of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0102	Peri od: W	Worksheet B

COST ALLOCATION - GENERAL SERVICE COSTS		FI OVI dei Co	F	rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre 5/30/2022 10:	pared: 09 am
		CAPI TAL REI	_ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	col . 7)	1.00	2.00	4.00	4.0	
110 00 11000 INTECTIMAL ACQUICITION	0	1.00	2.00	4. 00	4A	110.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0		110. 00 111. 00
111. 00 11100 I SLET ACQUI SI TI ON	٥	U	١	U	U	
113. 00 11300 INTEREST EXPENSE						113.00
114. 00 11400 UTILIZATION REVIEW-SNF		0	_			114. 00 115. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116.00 11600 HOSPICE	0	0			l .	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	15, 869, 530	229, 825	312, 517	1, 084, 943		
NONREI MBURSABLE COST CENTERS	13, 609, 330	229, 023	312, 317	1, 004, 943	15, 707, 610	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ام	1, 776	2, 415		/ 101	190. 00
191. 00 19100 RESEARCH	0	1, 770	2,410	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		0		0		192. 00
193. 00 19300 NONPAI D WORKERS		0	ĺ	0		193. 00
194. 00 07950 SPECIALTY CLINICS / MOB	0	66, 840	90, 889	0	157, 729	
200.00 Cross Foot Adjustments		00,010	,0,00,			200.00
201.00 Negative Cost Centers		0	1	0	l e	201. 00
202.00 TOTAL (sum lines 118 through 201)	15, 869, 530	298, 441	405, 821	1, 084, 943	l .	1

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0102

Peri od: Worksheet B From 01/01/2021 Part I To 12/31/2021 Date/Ti me Prepared:

5/30/2022 10:09 am Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 4, 319, 051 5 00 5 00 7.00 00700 OPERATION OF PLANT 729, 019 2, 689, 658 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 49, 265 181, 760 8.00 9.00 00900 HOUSEKEEPI NG 130, 212 94. 455 574.863 9.00 01000 DI ETARY 99, 833 240, 746 10.00 31, 632 2.095 22, 114 10.00 01100 CAFETERI A 91,007 27, 211 6,027 11.00 11.00 0 13 00 01300 NURSING ADMINISTRATION 144,611 12, 548 0 2,780 0 13.00 01400 CENTRAL SERVICES & SUPPLY 63, 890 92, 541 0 14 00 14 00 14, 152 0 15.00 01500 PHARMACY 122, 469 43, 666 0 9,672 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 73.393 35, 990 0 7,972 0 16.00 01700 SOCIAL SERVICE 26, 867 17.00 17.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 527, 853 357, 598 39, 408 79, 211 196, 043 30.00 03100 INTENSIVE CARE UNIT 31.00 0 C 0 0 31.00 04000 SUBPROVI DER - I PF 0 0 0 40.00 40.00 0 0 04100 SUBPROVIDER - IRF 0 41.00 0 C 0 0 41.00 04300 NURSERY 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 388, 761 50.00 198,019 14, 341 86, 114 0 50.00 51.00 05100 RECOVERY ROOM C 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 52.00 05300 ANESTHESI OLOGY 53.00 53.00 168 05400 RADI OLOGY-DI AGNOSTI C 54.00 293.739 165, 056 31, 484 36, 561 Λ 54 00 54.01 05401 ULTRASOUND 37, 277 0 54.01 C 05500 RADI OLOGY-THERAPEUTI C 55.00 0 0 55.00 05600 RADI OI SOTOPE 0 56.00 17.218 0 56.00 05700 CT SCAN 57.00 28, 341 22,063 0 4.887 0 57.00 58.00 05800 MRI 14, 918 58, 190 12,890 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 0 59.00 60 00 06000 LABORATORY 372 701 90, 181 0 19, 976 60 00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 0 0 62.00 06400 I NTRAVENOUS THERAPY 0 64.00 C 0 64.00 65.00 06500 RESPIRATORY THERAPY 155, 836 39, 069 3.363 65.00 8.654 0 06600 PHYSI CAL THERAPY 6, 123 66.00 224, 787 98, 638 21, 849 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 C 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 0 0 68.00 69 00 06900 ELECTROCARDI OLOGY 20, 224 O 4 480 69 00 60.655 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 15, 781 0 0 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 0 237.746 73 00 73 00 C 0 74.00 07400 RENAL DIALYSIS 0 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 03030 ANGI OCARDI OGRAPHY 76, 00 0 0 76, 00 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 0 0 89.00 09000 CLI NI C 90.00 0 90.00 0 0 0 187, 946 91.00 09100 EMERGENCY 582, 790 84.946 41,632 Ω 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 94.00 0 0 95.00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 0 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 96.00 0 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 0 97.00 0 99.00 99.00 09900 CMHC 0 0 0 0 0 99.10 09910 CORF C 0 0 99.10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 101, 00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 105. 00 0 106.00 10600 HEART ACQUISITION 0 0 0 0 106.00 0 107. 00 10700 LIVER ACQUISITION 0 0 107, 00 C 0 108.00 10800 LUNG ACQUISITION 0 108.00 0 109.00 10900 PANCREAS ACQUISITION 0 0 0 109.00 o 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 0 0 111.00 11100 | SLET ACQUISITION 0 0 1111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115.00 Health Financial Systems

STARKE MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0102
From 01/01/2021
To 12/31/2021
Date/Time Prepared:

					5/30/2022 10:	09 am_
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5.00	7. 00	8.00	9. 00	10.00	
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	4, 258, 845	1, 805, 319	181, 760	378, 971	196, 043	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 558	22, 890	0	5, 070	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	0	0	0	44, 703	192.00
193.00 19300 NONPALD WORKERS	o	0	0	0	0	193. 00
194.00 07950 SPECIALTY CLINICS / MOB	58, 648	861, 449	0	190, 822	0	194. 00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	o	0	0	o	0	201.00
202.00 TOTAL (sum lines 118 through 201)	4, 319, 051	2, 689, 658	181, 760	574, 863	240, 746	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0102

Peri od: Worksheet B From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared:

5/30/2022 10:09 am Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL SERVICES & RECORDS & ADMI NI STRATI ON SUPPLY LI BRARY 11. 00 13.00 15.00 14.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 369,002 11.00 01300 NURSING ADMINISTRATION 16, 586 13.00 565, 447 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 9 239 428, 705 14 00 15.00 01500 PHARMACY 14,857 227 520, 262 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 7,780 105 322, 624 16.00 01700 SOCIAL SERVICE 3, 188 17.00 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 34, 499 19, 037 69, 316 237.840 30.00 03100 INTENSIVE CARE UNIT 0 31.00 C 31.00 0 0 04000 SUBPROVIDER - IPF 0 0 40 00 0 C Ω 40.00 41.00 04100 SUBPROVI DER - I RF 0 C 0 0 0 41.00 04300 NURSERY 43.00 0 0 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 21, 178 46, 951 74, 171 0 21, 338 50.00 51.00 05100 RECOVERY ROOM C 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 0 52.00 0 4, 951 53 00 05300 ANESTHESI OLOGY 295 53 00 0 |05400| RADI OLOGY-DI AGNOSTI C 54.00 37, 765 9, 925 14,814 17,812 54.00 0 05401 ULTRASOUND 8, 938 54.01 4,646 923 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 C 05600 RADI OI SOTOPE 56.00 432 C 5, 678 2, 061 56,00 57.00 05700 CT SCAN 3,080 11,056 41,660 57.00 11, 236 58.00 05800 MRI 1,513 122 0 58.00 59 00 05900 CARDIAC CATHETERIZATION 59 00 C0 60.00 06000 LABORATORY 48, 516 155, 767 67, 320 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 0 62.00 0 64.00 06400 I NTRAVENOUS THERAPY 64.00 0 06500 RESPIRATORY THERAPY 3, 047 65 00 24.744 Ω 3.125 65 00 06600 PHYSI CAL THERAPY 0 66.00 35, 171 C 1, 292 12, 361 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 68.00 \cap 06900 ELECTROCARDI OLOGY 69 00 9.509 11 1, 472 13, 166 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 22, 632 0 606 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 30,063 575 72.00 0 07300 DRUGS CHARGED TO PATIENTS 520, 262 73.00 0 0 37, 560 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 03030 ANGI OCARDI OGRAPHY 76.00 0 0 0 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 0 0 0 o 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 O 89.00 09000 CLINIC 90.00 0 0 0 90.00 91.00 09100 EMERGENCY 61, 482 270, 720 72, 464 0 60, 956 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 94.00 09500 AMBULANCE SERVICES 0 0 0 95.00 95.00 0 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 0 0 0 97.00 0 0 99.00 09900 CMHC C 0 0 99.00 99. 10 09910 CORF 0 0 0 0 99.10 0 0 o 100.00 10000 I &R SERVICES-NOT APPRVD PRGM C 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 С 0 0 105. 00 0 0 106. 00 10600 HEART ACQUISITION 0 0 0 106, 00 107. 00 10700 LIVER ACQUISITION 0 0 107, 00 0 108.00 10800 LUNG ACQUISITION 0 0 0 0 0 108.00 0 0 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110 00 Ω 111.00 11100 I SLET ACQUISITION 0 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS STARKE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0102

					5/30/2022 10:	09 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16.00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	369, 002	565, 447	428, 705	520, 262	322, 624	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 SPECIALTY CLINICS / MOB	0	o	0	o	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	o	0	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	369, 002	565, 447	428, 705	520, 262	322, 624	202. 00

	Financial Systems	STARKE MEMORIAL				u of Form CMS-2	<u> 2552-10</u>
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der CC		Period: From 01/01/2021	Worksheet B Part I	
					o 12/31/2021	Date/Time Pre	pared:
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern &	Total	5/30/2022 10:	09 am
	Cost Center Description	SUCIAL SERVICE		Residents Cost			
				& Post			
				Stepdown			
		47.00	04.00	Adjustments	24.00		
	GENERAL SERVICE COST CENTERS	17. 00	24. 00	25. 00	26. 00		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCIAL SERVICE	102, 313				_	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	102, 313	3, 082, 741				30.00
40.00	04000 SUBPROVI DER – I PF	0	0				40.00
41. 00	04100 SUBPROVI DER – I RF	o	Ö	ď			41. 00
43.00	04300 NURSERY	0	0		0		43.00
FO 00	ANCILLARY SERVICE COST CENTERS		1 202 420		1 202 420		F0 00
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	0	1, 383, 430		1		50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	o	Ö	ď	-		52. 00
53. 00	05300 ANESTHESI OLOGY	0	5, 866	C	-,		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 397, 146				54.00
54. 01 55. 00	05401 ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C	0	152, 038		152, 038		54. 01 55. 00
56. 00	05600 RADI OI SOTOPE	0	71, 696		71, 696		56. 00
57. 00	05700 CT SCAN	0	187, 307	C	187, 307		57. 00
58. 00	05800 MRI	0	138, 989	(138, 989		58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0 1, 756, 813		1, 756, 813		59. 00 60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		1, 750, 015		0		62. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0	C	o		64. 00
65. 00	06500 RESPI RATORY THERAPY	0	656, 947	C			65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	1, 004, 769		1, 004, 769		66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0				68. 00
	06900 ELECTROCARDI OLOGY	0	272, 645	C	272, 645		69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	C	'I "I		70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	-42, 055 88, 861		-42, 055		71. 00 72. 00
	07300 DRUGS CHARGED TO PATTENTS	0	1, 434, 968		88, 861 1, 434, 968		73. 00
	07400 RENAL DIALYSIS	o	0	ď	0		74. 00
	07500 ASC (NON-DISTINCT PART)	0	0	C	o		75. 00
76. 00	O3030 ANGI OCARDI OGRAPHY OUTPATI ENT SERVI CE COST CENTERS	0	0		0		76. 00
88. 00		0	0		0		88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	o		89. 00
	09000 CLI NI C	0	0	C	0		90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 930, 309				91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS				/		92.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	C	0		94. 00
	09500 AMBULANCE SERVI CES	0	0	(0		95. 00
	09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0		96. 00 97. 00
	09900 CMHC	0	0				99.00
	09910 CORF	0	0	d	o		99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	C			100.00
101.00	10100 HOME HEALTH AGENCY	0	0		0		101. 00
105.00	SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION	0	O		0		105. 00
	10600 HEART ACQUISITION		0		1		106. 00
	10700 LIVER ACQUISITION	0	0	C	o		107. 00
	10800 LUNG ACQUISITION	0	0				108.00
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION		0				109. 00 110. 00
	11100 SLET ACQUISITION		Ö		o o		111.00
		· · ·					

Health Financial Systems	STARKE MEMORIA	L HOSPITAL		In Lie	eu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co	CN: 15-0102	Peri od:	Worksheet B
				From 01/01/2021	
				To 12/31/2021	Date/Time Prepared: 5/30/2022 10:09 am
Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern &	Total	373072022 10.04 alli
oost content boson per on	SOUTHE SERVICE		Residents Cos		
			& Post		
			Stepdown		
			Adjustments		
	17. 00	24. 00	25. 00	26.00	
113. 00 11300 NTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	115. 00
116. 00 11600 HOSPI CE	0	0		0 0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	102, 313	14, 522, 470		0 14, 522, 470	118. 00
NONRE MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	33, 709		0 33, 709	
191. 00 19100 RESEARCH	0	0		0	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	44, 703		0 44, 703	
193. 00 19300 NONPALD WORKERS	0	0		0	193. 00
194.00 07950 SPECIALTY CLINICS / MOB	0	1, 268, 648		0 1, 268, 648	
200.00 Cross Foot Adjustments		0		0 0	200. 00
201.00 Negative Cost Centers	0	0		0	201. 00
202.00 TOTAL (sum lines 118 through 201)	102, 313	15, 869, 530		0 15, 869, 530	202. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0102

				To	12/31/2021	Date/Time Prep 5/30/2022 10:0	
			CAPI TAL RE	LATED COSTS		37 307 2022 10.	37 dili
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capital Related Costs				DEPARTMENT	
		0	1.00	2. 00	2A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT		Γ				1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	596	1	1, 406	1, 406	4. 00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	20, 153 69, 002		47, 558 162, 829	170 0	5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	0,7,552		0	89	8. 00
9.00	00900 HOUSEKEEPI NG	0	7, 329		17, 295	0	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	7, 746 2, 111	1	18, 279 4, 982	40	10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	974		2, 298	34	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	4, 957		11, 698	64	14.00
15. 00 16. 00	O1500 PHARMACY O1600 MEDI CAL RECORDS & LI BRARY	0	3, 388 2, 792		7, 995 6, 589	16 53	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	_,	1	0	10	17. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	27, 746	37, 729	65, 475	211	30. 00
31.00	03100 INTENSIVE CARE UNIT	0	27, 740		05, 475	0	31. 00
40.00	04000 SUBPROVI DER - I PF	0	O	0	0	0	40. 00
41. 00 43. 00	04100 SUBPROVI DER - RF 04300 NURSERY	0		0	0	0	41. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	0		0	O	0	43.00
50.00	05000 OPERATI NG ROOM	0	30, 164		71, 181	58	50. 00
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	Ö	Ö	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	12, 807	_	30, 222	110	54. 00
54. 01 55. 00	05401 ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C	0		0	0	13	54. 01 55. 00
56. 00	05600 RADI OI SOTOPE	0	Ö	Ö	0	2	56. 00
57.00	05700 CT SCAN	0	1, 712		4, 040	9	57. 00
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	4, 515	6, 139 0	10, 654 0	5 0	58. 00 59. 00
60.00	06000 LABORATORY	0	6, 997	9, 515	16, 512	110	60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	_	0	0	62.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	3, 031	0 4, 122	0 7, 153	0 68	64. 00 65. 00
66.00	06600 PHYSI CAL THERAPY	0	7, 653	1	18, 060	96	66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	1, 569	_	3, 703	26	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71.00	O7100 MEDICAL SUPPLIES CHARGED TO PATIENT O7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	Ö	0	0	0	73. 00
74. 00	07400 RENAL DI ALYSI S	0	0	0	0	0	74. 00
75. 00 76. 00	O7500 ASC (NON-DISTINCT PART) O3030 ANGIOCARDIOGRAPHY	0		0	0	0	75. 00 76. 00
70.00	OUTPATIENT SERVICE COST CENTERS			3		0	70.00
	08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89. 00 90. 00
91. 00	09100 EMERGENCY	0	14, 583	19, 830	34, 413	216	91. 00
92. 00	O9200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REIMBURSABLE COST CENTERS				0		92. 00
94. 00	09400 HOME PROGRAM DIALYSIS	0	О	O	0	0	94. 00
95.00	09500 AMBULANCE SERVICES	0	O	0	0	0	95. 00
	O9600 DURABLE MEDICAL EQUIP-RENTED O9700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	96. 00 97. 00
	09900 CMHC	0		0	0	0	99. 00
	09910 CORF	0	0	0	0	0	99. 10
	10000 &R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0	0	0	0		100. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS			. 0		0	131.00
	10500 KIDNEY ACQUISITION	0	O		0		105. 00
	10600 HEART ACQUISITION 10700 LIVER ACQUISITION	0	0	0	0		106. 00 107. 00
108.00	10800 LUNG ACQUISITION	0	0	o o	0	0	108. 00
	10900 PANCREAS ACQUISITION	0	0	0	0		109.00
110.00	11000 INTESTINAL ACQUISITION	1 0	1 0	0	0	0	110. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021

			10	12/31/2021	5/30/2022 10:	
		CAPI TAL REL	ATED COSTS			
		DI DO A FLIVE	10/DL 5 50/U.S		ENDL OVEE	
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFITS	
	Capital Related Costs				DEPARTMENT	
	0	1. 00	2. 00	2A	4. 00	
111. 00 11100 SLET_ACQUI SI TI ON	0	0	0	0		111. 00
113. 00 11300 NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	o	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	O	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	229, 825	312, 517	542, 342	1, 406	118. 00
NONRE MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 776	2, 415	4, 191		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
193. 00 19300 NONPAI D WORKERS	0	0	0	0		193. 00
194. 00 07950 SPECIALTY CLINICS / MOB	0	66, 840	90, 889	157, 729		194. 00
200.00 Cross Foot Adjustments		0	0	0		200.00
201.00 Negative Cost Centers		209 441	405 921	704 242		201. 00
202.00 TOTAL (sum lines 118 through 201)	U	298, 441	405, 821	704, 262	1, 406	202. 00

Provider CCN: 15-0102

| Period: | Worksheet B | From 01/01/2021 | Part II | Date/Time Prepared: | 5/30/2022 | 10: 09 am

	ADMINI CEDATINE	ODEDATION OF	L ALINIDDY A	LIQUISEKEEDI NO	5/30/2022 10:	
Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	5. 00	7. 00	8.00	9. 00	10.00	
GENERAL SERVICE COST CENTERS			I			1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	47, 728					5. 00
7.00 O0700 OPERATION OF PLANT	8, 057	170, 886				7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	544	0	633			8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	1, 439 350		0	24, 735 952	25, 971	9. 00 10. 00
11. 00 01100 CAFETERI A	1, 006	1		259	25, 9/1	11.00
13. 00 01300 NURSI NG ADMINI STRATI ON	1, 598			120	0	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	1, 023	4, 059		609	0	14. 00
15. 00 01500 PHARMACY	1, 353	2, 774	0	416	0	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	811	2, 287	0	343	0	16.00
17. 00 O1700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	297	0	0	0	0	17. 00
30. 00 03000 ADULTS & PEDIATRICS	5, 833	22, 720	137	3, 408	21, 149	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	0	· · · · · · · · · · · · · · · · · · ·	0	31. 00
40. 00 04000 SUBPROVI DER - PF	0	0	0	0	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	43. 00
50. 00 05000 OPERATING ROOM	2, 188	24, 700	50	3, 705	0	50.00
51. 00 05100 RECOVERY ROOM	0	0	0	0, 700	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	o	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	2	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 246	10, 487	110	1, 573	0	54.00
54. 01 05401 ULTRASOUND 55. 00 05500 RADI OLOGY-THERAPEUTI C	412	0	0	0	0	54. 01 55. 00
56. 00 05600 RADI 01 SOTOPE	190	0	0	0	0	56.00
57. 00 05700 CT SCAN	313	l	Ö	210	0	57. 00
58. 00 05800 MRI	165	3, 697	0	555	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 06000 LABORATORY	4, 119	5, 730		860	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	62. 00 64. 00
65. 00 06500 RESPI RATORY THERAPY	1, 722	2, 482	_	372	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 484	6, 267		940	0	66. 00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	670	1, 285	0	193	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	70. 00 71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	174	o o	Ö	ő	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 627	0	0	0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	0	0	0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76. 00 03030 ANGI OCARDI OGRAPHY OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76. 00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ö	0	0	0	89. 00
90. 00 09000 CLI NI C	0	0	0	0	0	90. 00
91. 00 09100 EMERGENCY	6, 440	11, 941	296	1, 791	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	Ö	Ö	ő	0	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
99. 00 09900 CMHC	0	0	0	0	0	
99. 10 09910 CORF	0	0	0	0	0	99. 10 100. 00
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0 0		0	0		100.00
SPECIAL PURPOSE COST CENTERS				<u> </u>		101.00
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION	0	0	0	0		108. 00 109. 00
110.00 11000 INTESTINAL ACQUISITION		0				1109.00
111. 00 11100 SLET ACQUI SI TI ON	0	0	Ö	Ö		111.00
113. 00 11300 I NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	<u> </u> 0	0	115. 00

Health Financial Systems STARKE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0102 | Peri od: From 01/01/2021 | Part II To 12/31/2021 | Date/Time Prepared:

			''	0 12/31/2021	5/30/2022 10:	
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5. 00	7.00	8. 00	9. 00	10.00	
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	47, 063	114, 701	633	16, 306	21, 149	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	17	1, 454	0	218	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	4, 822	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 SPECIALTY CLINICS / MOB	648	54, 731	0	8, 211	0	194. 00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	47, 728	170, 886	633	24, 735	25, 971	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0102

Peri od: Worksheet B From 01/01/2021 Part II To 12/31/2021 Date/Time Prepared:

5/30/2022 10:09 am Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL RECORDS & SERVICES & ADMI NI STRATI ON SUPPLY LI BRARY 11. 00 13.00 15.00 14.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 7, 982 11.00 01300 NURSING ADMINISTRATION 359 13.00 5, 206 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 200 17,653 14 00 15.00 01500 PHARMACY 321 0 12,884 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 10, 255 16.00 168 01700 SOCIAL SERVICE 0 17.00 69 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 604 1.499 2, 190 1, 421 30.00 0 03100 INTENSIVE CARE UNIT 0 31.00 0 31.00 C 04000 SUBPROVI DER - I PF 0 0 40 00 C 0 0 40.00 41.00 04100 SUBPROVI DER - I RF 0 C 0 0 0 41.00 04300 NURSERY 43.00 0 0 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 458 432 3,054 0 677 50.00 51.00 05100 RECOVERY ROOM 0 C C 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 0 0 0 0 0 52.00 53 00 05300 ANESTHESI OLOGY 0 C 157 53 00 12 |05400| RADI OLOGY-DI AGNOSTI C 54.00 817 91 610 565 54.00 05401 ULTRASOUND 284 54.01 101 38 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 55.00 0 05600 RADI OI SOTOPE 9 56.00 C 234 65 56.00 57.00 05700 CT SCAN 67 455 1, 323 57.00 58.00 05800 MRI 33 5 0 357 58.00 59 00 05900 CARDIAC CATHETERIZATION 59 00 0 0 0 1, 049 6, 414 60.00 06000 LABORATORY 2, 152 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 62.00 C 0 0 0 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 0 0 06500 RESPIRATORY THERAPY 97 65 00 535 129 65 00 06600 PHYSI CAL THERAPY 66.00 761 53 392 66.00 0 06700 OCCUPATIONAL THERAPY 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 06900 ELECTROCARDI OLOGY 69 00 206 61 418 69 00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 932 0 19 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 18 72.00 1, 238 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 C 12.884 1.192 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 03030 ANGI OCARDI OGRAPHY 0 0 76.00 0 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 0 0 0 o 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 O 89.00 09000 CLINIC 90.00 0 0 0 0 90.00 91.00 09100 EMERGENCY 1, 330 2, 493 2.984 0 1, 935 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 94.00 09500 AMBULANCE SERVICES 0 0 0 95.00 95.00 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 0 97.00 0 0 99.00 09900 CMHC C 0 0 99.00 99. 10 09910 CORF 0 0 0 0 99.10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 o 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 105. 00 0 С 0 0 0 106. 00 10600 HEART ACQUISITION 0 0 0 106, 00 107. 00 10700 LIVER ACQUISITION 0 0 107, 00 0 108.00 10800 LUNG ACQUISITION 0 0 0 0 0 108.00 0 0 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110 00 Ω 111.00 11100 I SLET ACQUISITION 0 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS STARKE MEMORIAL HOSPITAL Provider CCN: 15-0102

| Period: | Worksheet B | From 01/01/2021 | Part II | Date/Time Prepared: | 5/30/2022 | 10: 09 am

					5/30/2022 10:	<u>09 alli</u>
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15.00	16. 00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 982	5, 206	17, 653	12, 884	10, 255	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 SPECIALTY CLINICS / MOB	0	0	0	0	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	o	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	7, 982	5, 206	17, 653	12, 884	10, 255	202. 00

	Financial Systems	STARKE MEMURIA				u of form CMS	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der CC		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/30/2022 10:	epared: 09 am
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	Total t		
	Tanana	17. 00	24. 00	25. 00	26. 00		
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	<u> </u>		<u> </u>			1.00
2. 00 4. 00 5. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						2. 00 4. 00 5. 00
7. 00 8. 00 9. 00 10. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY						7. 00 8. 00 9. 00 10. 00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON						11. 00 13. 00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14. 00 15. 00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	376					16. 00
.,, 00	INPATIENT ROUTINE SERVICE COST CENTERS	0,0					177.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	376 0	125, 023 0		0 125, 023		30. 00 31. 00
40.00	04000 SUBPROVI DER - I PF	0	0		0 0		40. 00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0	0		0 0 0		41. 00 43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	O	106, 503		0 106, 503		50.00
51.00	05100 RECOVERY ROOM	0	0		0		51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0 171		0 0 171		52. 00 53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	Ö	47, 831		0 47, 831		54. 00
54. 01 55. 00	05401 ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C	0	848 0		0 848		54. 01 55. 00
56.00	05600 RADI OI SOTOPE	Ö	500		500		56. 00
57. 00 58. 00	05700 CT SCAN	0	7, 819 15, 471		0 7, 819 0 15, 471		57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0		59. 00
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	36, 946 0		0 36, 946		60. 00 62. 00
64. 00	06400 I NTRAVENOUS THERAPY	Ö	0		0 0		64. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	12, 570 29, 074		0 12, 570 0 29, 074	1	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	Ö	27, 37 1		0 0		67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0 6, 562		0 0 6, 562		68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	l	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 MPL. DEV. CHARGED TO PATIENTS	0	951 1, 430		0 951 0 1, 430		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	16, 703		0 16, 703	l .	73. 00
74. 00 75. 00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	0		0		74. 00 75. 00
76. 00	03030 ANGI OCARDI OGRAPHY	0	0		0 0		76. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0		0 0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89. 00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	0	63, 839		0 0 63, 839		90. 00 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		·		0		92. 00
94. 00	09400 HOME PROGRAM DI ALYSI S	0	0		0 0		94. 00
95. 00 96. 00	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0		95. 00 96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0		97. 00
	09900	0	0		0		99. 00 99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0		100. 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0 0		101. 00
	10500 KIDNEY ACQUISITION	0	0		0 0		105. 00
	0 10600 HEART ACQUISITION 0 10700 LIVER ACQUISITION	0	0		0		106. 00 107. 00
108.00	10800 LUNG ACQUISITION	0	0		o o		108. 00
) 10900 PANCREAS ACQUISITION) 11000 INTESTINAL ACQUISITION	0	0		0		109. 00 110. 00
	11100 I SLET ACQUISITION	0		<u> </u>	o o	<u> </u>	111.00

Health Financial Systems	STARKE MEMORIA	L HOSPITAL		In Lie	eu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B
				From 01/01/2021 To 12/31/2021	
				10 12/31/2021	Date/Time Prepared: 5/30/2022 10:09 am
Cost Center Description	SOCIAL SERVICE	Subtotal	Intern &	Total	9, 50, 2022 10, 5, 4,
			Residents Cos	t	
			& Post		
			Stepdown		
			Adjustments		
	17. 00	24. 00	25. 00	26. 00	
113. 00 11300 I NTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0	115. 00
116. 00 11600 HOSPI CE	0	0		0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	376	472, 241		0 472, 241	118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5, 880		0 5, 880	
191. 00 19100 RESEARCH	0	0		0 0	191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	4, 822		0 4, 822	192. 00
193. 00 19300 NONPALD WORKERS	0	0		0 0	193. 00
194. 00 07950 SPECIALTY CLINICS / MOB	0	221, 319		0 221, 319	
200.00 Cross Foot Adjustments		0		0	200. 00
201.00 Negative Cost Centers	0	0		0	201. 00
202.00 TOTAL (sum lines 118 through 201)	376	704, 262		0 704, 262	202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0102 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/30/2022 10:09 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5. 00 5A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 83 683 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 83, 683 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 167 167 6, 766, 247 00500 ADMINISTRATIVE & GENERAL 11, 615, 772 5 00 5 651 815, 500 -4, 319, 051 5 00 5 651 7.00 00700 OPERATION OF PLANT 19, 348 19, 348 1, 960, 639 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 428, 056 132, 495 8.00 00900 HOUSEKEEPI NG 2,055 2,055 0 350, 196 9.00 9.00 0 01000 DI ETARY 190, 889 85, 072 10 00 10 00 2.172 2, 172 11.00 01100 CAFETERI A 592 592 28, 469 244, 757 11.00 01300 NURSING ADMINISTRATION 273 o 388, 922 13.00 273 163, 382 13.00 0 01400 CENTRAL SERVICES & SUPPLY 248, 883 14.00 1.390 1.390 306, 641 14.00 79, 199 15.00 01500 PHARMACY 950 950 329, 371 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 783 783 255, 199 0 197, 384 16.00 01700 SOCIAL SERVICE 17.00 48, 369 72, 258 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7.780 7.780 1, 015, 281 0 1, 419, 623 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 40.00 04000 SUBPROVIDER - IPF 0 Ω 0 0 O 40.00 04100 SUBPROVI DER - I RF 0 41.00 0 0 41.00 C 0 04300 NURSERY 0 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 8, 458 8, 458 279, 076 532, 557 50.00 05100 RECOVERY ROOM 0 51.00 C 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 0 52.00 0 05300 ANESTHESI OLOGY 53.00 0 0 452 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 591 3.591 529, 948 789, 990 54.00 54.01 05401 ULTRASOUND 62,827 100, 254 54.01 05500 RADI OLOGY-THERAPEUTI C 55, 00 55.00 56.00 05600 RADI OI SOTOPE 0 7, 954 0 46, 307 56.00 05700 CT SCAN 57 00 480 480 44.619 76, 220 57 00 58.00 05800 MRI 1, 266 22, 362 40, 120 58.00 1, 266 05900 CARDIAC CATHETERIZATION 59.00 0 59.00 06000 LABORATORY 1, 962 1, 962 1,002,352 60.00 527, 237 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 \cap Λ 62.00 64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 0 65.00 06500 RESPIRATORY THERAPY 850 850 329, 075 419, 109 65.00 06600 PHYSI CAL THERAPY 66 00 2 146 2 146 462, 350 604 548 66 00 06700 OCCUPATIONAL THERAPY 0 67.00 0 C 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 69.00 440 440 124, 014 0 163, 128 69.00 07000 ELECTROENCEPHALOGRAPHY 70 00 0 0 70 00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 65, 293 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 42, 442 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 0 0 639, 400 73.00 0 07400 RENAL DIALYSIS 74 00 Ω 0 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0 C 0 0 0 75.00 03030 ANGI OCARDI OGRAPHY ol 76.00 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 0 90.00 09000 CLI NI C 0 0 90 00 91 00 09100 EMERGENCY 4.089 4,089 1,045,800 0 1, 567, 373 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 94.00 0 0 0 09500 AMBULANCE SERVICES 0 95.00 0 95.00 0 0 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97 00 0 97 00 0 0 09900 CMHC 0 99.00 99.00 0 0 09910 CORE 0 99 10 99 10 C 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 Ω 0 0 0 105, 00 106.00 10600 HEART ACQUISITION 0 0 0 0 0 106.00 107. 00 10700 LIVER ACQUISITION 0 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 0 0 108, 00 0 109.00 10900 PANCREAS ACQUISITION 0 0 109.00

Provider CCN: 15-0102

			Т	o 12/31/2021	Date/Time Pre 5/30/2022 10:	
	CAPITAL REL	ATED COSTS				
Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	
	(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT		(ACCUM. COST)	
			(GROSS		(ACCOM. COST)	
			SALARI ES)			
	1.00	2.00	4. 00	5A	5. 00	
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110. 00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				0		114. 00 115. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE	0	0	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	64, 443	64, 443	6, 766, 247	-4, 253, 758		
NONREI MBURSABLE COST CENTERS	04, 443	07, 770	0, 700, 247	4, 255, 750	11, 433, 032	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	498	498	0	0	4, 191	190. 00
191. 00 19100 RESEARCH	0	O	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 SPECIALTY CLINICS / MOB	18, 742	18, 742	0	0	157, 729	
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	000 444	405 004	4 004 040		4 040 054	201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	298, 441	405, 821	1, 084, 943		4, 319, 051	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	3. 566328	4. 849503	0. 160346		0. 371826	203 00
204.00 Cost to be allocated (per Wkst. B,	0.000020	1. 0 17000	1, 406			204. 00
Part II)			.,		,.==	
205.00 Unit cost multiplier (Wkst. B, Part			0. 000208		0. 004109	205. 00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						207.00
	1			1	ı	1

Health Financial Systems		STARKE MEMORI	u of Form CMS-	2552-10			
COST A	ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	pared:
						5/30/2022 10:	09 am
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DIETARY	CAFETERI A	
		PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	(FTE)	
		(SQUARE TELT)	LAUNDRY)				
		7. 00	8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	E0 E17					5.00
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE	58, 517	56, 311				7. 00 8. 00
9. 00	00900 HOUSEKEEPING	2, 055	l .	56, 462			9.00
10. 00	01000 DI ETARY	2, 172	l .				10.00
11. 00	01100 CAFETERI A	592	l .	592		6, 830	
13.00	01300 NURSING ADMINISTRATION	273	0	273	0	307	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 390	l .	1, 390		171	
15. 00	01500 PHARMACY	950	l .	950		275	
16.00	01600 MEDICAL RECORDS & LIBRARY	783	l .	783		144	
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0	(0	59	17. 00
30. 00	03000 ADULTS & PEDIATRICS	7, 780	12, 209	7, 780	6, 837	1, 283	30.00
	03100 NTENSI VE CARE UNI T	0	0	,,,,,	0	0	
40.00	04000 SUBPROVI DER - I PF	0	0	(0	0	1
41.00	04100 SUBPROVI DER - I RF	0	0	(0	0	41. 00
43.00	04300 NURSERY	0	0	(0	0	43. 00
	ANCILLARY SERVICE COST CENTERS			I			
50.00	05000 OPERATI NG ROOM	8, 458	4, 443	8, 458		392	
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM		0		0	0	
53. 00	05300 ANESTHESI OLOGY		0			0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 591	9, 754	3, 59		699	1
54. 01	05401 ULTRASOUND	0		(o o	86	1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0	1
56.00	05600 RADI OI SOTOPE	0	0	(0	8	56. 00
57. 00	05700 CT SCAN	480		480		57	
58. 00	05800 MRI	1, 266	0	1, 266	0	28	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1 043	0	1 04	0	0 898	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 962	l .	1, 962		090	1
64. 00	06400 I NTRAVENOUS THERAPY		_		-	0	
65. 00	06500 RESPIRATORY THERAPY	850	1, 042	850	o o	458	
66.00	06600 PHYSI CAL THERAPY	2, 146	1, 897	2, 146	0	651	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	
68. 00	06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	440		440		176	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0			0	70.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0			0	
	07300 DRUGS CHARGED TO PATIENTS	0	Ö		o o	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	(0	0	74. 00
75.00		0	0	(0	0	75. 00
76. 00	03030 ANGI OCARDI OGRAPHY	0	0	(0	0	76. 00
00 00	OUTPATIENT SERVICE COST CENTERS			1 /		0	88.00
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER		0) 	89.00
	09000 CLINIC		0			0	90.00
	09100 EMERGENCY	4, 089	26, 317	4, 089	o o	1, 138	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	· ·				•	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09400 HOME PROGRAM DI ALYSI S	0	0	(0	0	94. 00
	09500 AMBULANCE SERVICES	0	0	(0	0	
	09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD		0			0	
	09900 CMHC		0			0	
	09910 CORF	0	Ö		o o	0	1
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	(0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0	0	(0	0	101. 00
	SPECIAL PURPOSE COST CENTERS	_	_	T			
	10500 KIDNEY ACQUISITION	0	0]			105.00
	10600 HEART ACQUISITION 10700 LIVER ACQUISITION		0]			106. 00 107. 00
	0 10700 LIVER ACQUISITION		0				107.00
	10800 PANCREAS ACQUISITION		0				109.00
	11000 INTESTINAL ACQUISITION		Ö		o o		110.00
111.00	11100 SLET ACQUISITION	0	0	(0	0	111. 00
113.00	11300 INTEREST EXPENSE						113. 00

Health Financial Systems	STARKE MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Pre 5/30/2022 10:	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	

			T	rom 01/01/2021 o 12/31/2021	Date/Time Pre	
					5/30/2022 10:	09 am
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(FTE)	
	(SQUARE FEET)	(POUNDS OF				
		LAUNDRY)				
	7. 00	8. 00	9. 00	10. 00	11. 00	
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	39, 277	56, 311	37, 222	6, 837	6, 830	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	498	0	498	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	1, 559	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 SPECIALTY CLINICS / MOB	18, 742	0	18, 742	0	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	2, 689, 658	181, 760	574, 863	240, 746	369, 002	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	45. 963703	3. 227789	10. 181414	28. 673892	54. 026647	203. 00
204.00 Cost to be allocated (per Wkst. B,	170, 886	633	24, 735	25, 971	7, 982	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	2. 920280	0. 011241	0. 438082	3. 093259	1. 168668	205. 00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						

	Financial Systems	STARKE MEMORIA				eu of Form CMS	
COSTA	ILLOCATION - STATISTICAL BASIS		Provi der CC	F	Period: From 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Pre 5/30/2022 10:	pared:
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	O7 alli
	·	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LIBRARY	(TIME SPENT)	
		(TOTAL NURS	(COSTED		(GROSS CHAR		
		ING SALAR) 13.00	REQUI S.) 14. 00	15. 00	GES) 16. 00	17. 00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	.0.00	10.00	177.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11.00	01100 CAFETERI A	0.000.504					11.00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	2, 033, 521	656, 231				13. 00 14. 00
15. 00	01500 PHARMACY	0	348	647, 317	7		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	160	(16. 00
17. 00	01700 SOCIAL SERVICE	0	0	(0	1, 785	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	855, 345	52, 809	(4, 648, 925		
40.00	04000 SUBPROVI DER - I PF	0	0	(0	
41. 00	04100 SUBPROVI DER - I RF		o	(0	
43.00	04300 NURSERY	0	0	(0	0	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	168, 850	113, 536	(
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	452	(1, 209, 109	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	35, 693	22, 676	(4, 349, 638	l .	54.00
54. 01	05401 ULTRASOUND	0	1, 413	(2, 182, 684	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0	55. 00
56. 00 57. 00	05600	0	8, 691 16, 923	(503, 334 10, 173, 464		56. 00 57. 00
58. 00	05800 MRI	0	186	(2, 743, 848		58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	o	0	(0	Ö	59. 00
60.00	06000 LABORATORY	0	238, 441	(16, 431, 337	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(0	0	62. 00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0 4, 783	(744, 027	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	1, 977	(3, 018, 544		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	O	0	(0	Ö	1
68. 00	06800 SPEECH PATHOLOGY	0	O	(0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	40	2, 253	(3, 215, 169		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0 34, 643	(0 147, 922		
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	46, 018	(147, 922		1
	07300 DRUGS CHARGED TO PATIENTS	0	0	647, 317			73. 00
74.00	07400 RENAL DIALYSIS	0	0	. (0	0	1
75. 00		0	0	(0	
76. 00	03030 ANGI OCARDI OGRAPHY OUTPATI ENT SERVI CE COST CENTERS	0	0	(0	0	76. 00
88. 00	08800 RURAL HEALTH CLINIC	0	ol	(0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0	0	
90.00	09000 CLI NI C	0	0	(0	0	
	09100 EMERGENCY	973, 593	110, 922	(14, 885, 453	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
94. 00	09400 HOME PROGRAM DI ALYSIS	0	O	(0	0	94.00
95. 00	i i	0	Ō	(Ö	0	
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	(0	0	
	09900	0	0	(0	0	
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	(-	100.00
	10100 HOME HEALTH AGENCY	0	Ō	(Ö		101. 00
	SPECIAL PURPOSE COST CENTERS						
	10500 KI DNEY ACQUI SI TI ON	0	0		0		105.00
	10600 HEART ACQUISITION 10700 LIVER ACQUISITION		0	(0		106. 00 107. 00
	10700 LIVER ACQUISITION		ol Ol	(o o		107.00
	10900 PANCREAS ACQUISITION		o	(o o		109. 00
	11000 INTESTINAL ACQUISITION	0	o	(0		110. 00
111.00	11100 SLET ACQUISITION	0	0	(0	0	111. 00

Heal th Finar	ncial Systems	STARKE MEMORIA	AL HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Period: Worksheet B- From 01/01/2021			
					To 12/31/2021	Date/Time Pre		
	·					5/30/2022 10:		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE		
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	(TIME CDENT)		
		(TOTAL NURS	SUPPLY (COSTED	REQUIS.)	LI BRARY (GROSS CHAR	(TIME SPENT)		
		ING SALAR)	REQUIS.)		GES)			
		13.00	14. 00	15. 00	16.00	17. 00		
113. 00 11300	INTEREST EXPENSE	10.00	11100	10100	10100	17100	113. 00	
	UTILIZATION REVIEW-SNF						114. 00	
	AMBULATORY SURGICAL CENTER (D. P.)	0	0		o o	0	115. 00	
116. 00 11600		O	0		0 0	0	116. 00	
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	2, 033, 521	656, 231	647, 31	7 78, 776, 530	1, 785	118. 00	
NONRE	EIMBURSABLE COST CENTERS							
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190. 00	
191. 00 19100		0	0		0		191. 00	
	PHYSICIANS' PRIVATE OFFICES	0	0		0		192. 00	
	NONPALD WORKERS	0	0		0		193. 00	
	SPECIALTY CLINICS / MOB	0	0		0	0	194. 00	
200.00	Cross Foot Adjustments						200. 00	
201.00	Negative Cost Centers						201. 00	
202.00	Cost to be allocated (per Wkst. B, Part I)	565, 447	428, 705	520, 26	2 322, 624	102, 313	202. 00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 278063	0. 653284	0. 80372	1 0. 004095	57. 318207	203. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)	5, 206	17, 653	12, 88	4 10, 255	376	204. 00	
205. 00	Unit cost multiplier (Wkst. B, Part	0. 002560	0. 026901	0. 01990	4 0. 000130	0. 210644	205. 00	
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00	
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co	Provi der CCN: 15-0102		Worksheet C Part I Date/Time Pre 5/30/2022 10:	pared: 09 am	
			Ti tl e	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	Costs RCE	Total Costs	
	cost center bescription	(from Wkst. B,	Adj.	Total Costs	Di sal I owance	Total Costs	
		Part I, col.	- 3				
		26)					
LNDAT	TIENT DOUTING CEDVICE COCT CENTEDS	1.00	2. 00	3. 00	4. 00	5. 00	
	TIENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	3, 082, 741		3, 082, 74	1 0	3, 082, 741	30.00
	INTENSIVE CARE UNIT	0		0,002,7.	o o	0	31.00
	SUBPROVIDER - IPF	0			0 0	0	40. 00
	SUBPROVI DER - I RF	0			0 0	0	41. 00
	NURSERY	0			0 0	0	43. 00
	LLARY SERVICE COST CENTERS OPERATING ROOM	1, 383, 430		1, 383, 43	ol o	1, 383, 430	50.00
	RECOVERY ROOM	0		1, 303, 43	0 0	1, 303, 430	51.00
	DELIVERY ROOM & LABOR ROOM	0			0 0	0	52. 00
	ANESTHESI OLOGY	5, 866		5, 86		5, 866	
	RADI OLOGY-DI AGNOSTI C	1, 397, 146		1, 397, 14		1, 397, 146	
	ULTRASOUND RADI OLOGY-THERAPEUTI C	152, 038		152, 03	0 0	152, 038 0	54. 01 55. 00
	RADI OLOGI - THERAPEUTI C	71, 696		71, 69	۳ _ا ۳۱	71, 696	1
	CT SCAN	187, 307		187, 30		187, 307	57. 00
58.00 05800		138, 989		138, 98		138, 989	58. 00
	CARDIAC CATHETERIZATION	0			0 0	0	59. 00
	LABORATORY	1, 756, 813		1, 756, 81	3 0	1, 756, 813	60.00
	WHOLE BLOOD & PACKED RED BLOOD CELL INTRAVENOUS THERAPY	0				0	62. 00 64. 00
	RESPI RATORY THERAPY	656, 947	0	656, 94	7 0	656, 947	1
	PHYSI CAL THERAPY	1, 004, 769	0	1		1, 004, 769	1
	OCCUPATIONAL THERAPY	0	0		0 0	0	67. 00
	SPEECH PATHOLOGY	0	0		0	0	68. 00
	ELECTROCARDI OLOGY	272, 645		272, 64	0	272, 645	1
	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENT	0				0	70. 00 71. 00
1	IMPL. DEV. CHARGED TO PATIENTS	88, 861		88, 86	1 0	88, 861	
	DRUGS CHARGED TO PATIENTS	1, 434, 968		1, 434, 96		1, 434, 968	1
	RENAL DIALYSIS	0			0 0	0	
	ASC (NON-DISTINCT PART)	0			0 0	0	75. 00
	ANGLOCARDLOGRAPHY ATLENT SERVICE COST CENTERS	l O			0 0	0	76. 00
	RURAL HEALTH CLINIC	0			0 0	0	88. 00
89. 00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0			o o	0	89. 00
	CLINIC	0			0 0	0	90. 00
	EMERGENCY	2, 930, 309		2, 930, 30		2, 930, 309	1
	OBSERVATION BEDS (NON-DISTINCT PART R REIMBURSABLE COST CENTERS	355, 935		355, 93	0	355, 935	92.00
	HOME PROGRAM DIALYSIS	0			0 0	0	94. 00
95.00 09500	AMBULANCE SERVICES	0			0 0	0	95. 00
	DURABLE MEDICAL EQUIP-RENTED	0			0	0	96.00
	DURABLE MEDICAL EQUIP-SOLD	0			0 0	0	97. 00
99. 00 09900 99. 10 09910						0	1
	I&R SERVICES-NOT APPRVD PRGM				0		100.00
	HOME HEALTH AGENCY	o			o l		101. 00
	AL PURPOSE COST CENTERS						
	KIDNEY ACQUISITION	0			0		105.00
	HEART ACQUISITION LIVER ACQUISITION	0			0		106. 00 107. 00
	LUNG ACQUISITION	0					107.00
	PANCREAS ACQUISITION	Ö			Ö		109. 00
	INTESTINAL ACQUISITION	0			0		110. 00
	I SLET ACQUISITION	0			0	0	111. 00
	INTEREST EXPENSE						113.00
	UTILIZATION REVIEW-SNF AMBULATORY SURGICAL CENTER (D.P.)					0	114. 00 115. 00
116. 00 11600					o l		116. 00
200. 00	Subtotal (see instructions)	14, 920, 460	0	14, 920, 46	0 0	14, 920, 460	
201. 00	Less Observation Beds	355, 935		355, 93	5	355, 935	201. 00
202. 00	Total (see instructions)	14, 564, 525	0	14, 564, 52	5 0	14, 564, 525	202. 00

Health Financial Systems	HOSPITAL In Lieu of F			2552-10	
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0102	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/30/2022 10:	
		Title XVIII	Hospi tal	PPS	
Charges					

					5/30/2022 10:	09 am
			XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				-		
30. 00 03000 ADULTS & PEDI ATRI CS	4, 648, 925		4, 648, 925			30. 00
31. 00 03100 INTENSIVE CARE UNIT	0		(31.00
40. 00 04000 SUBPROVI DER - PF	0		(40. 00
41. 00 04100 SUBPROVI DER - I RF	0)		41.00
43. 00 04300 NURSERY	0		()		43. 00
ANCI LLARY SERVI CE COST CENTERS	1 444 949	5 004 457		0.015400		
50. 00 05000 OPERATING ROOM	116, 013	5, 094, 657	1		0.000000	50.00
51. 00 05100 RECOVERY ROOM	0	0	1		0.000000	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	4 404 044	1 000 100	0.00000	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	24, 745	1, 184, 364			0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	220, 376	4, 129, 262			0.000000	54.00
54. 01 05401 ULTRASOUND	98, 114	2, 084, 570	2, 182, 684		0.000000	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	12 001	400 522	E02 22	0.000000	0.000000	55.00
56. 00 05600 RADI OI SOTOPE	12, 801	490, 533			0.000000	56.00
57. 00 05700 CT SCAN 58. 00 05800 MRI	1, 126, 726 130, 126	9, 046, 738			0.000000	57.00
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON	130, 126	2, 613, 722	2, 743, 848	0. 000000	0. 000000 0. 000000	58. 00 59. 00
60. 00 06000 LABORATORY	١	14 244 401	14 421 22		0. 000000	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2, 084, 656	14, 346, 681	16, 431, 337		0. 000000	62.00
64. 00 06400 NTRAVENOUS THERAPY	0	0		0. 000000	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	528, 285	215, 742	744, 02		0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	272, 827	2, 745, 717	1		0. 000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	272, 627	2, 745, 717	3,010,342	0. 000000	0. 000000	67.00
68. 00 06800 SPEECH PATHOLOGY		0		0.000000	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	498, 035	2, 717, 134	3, 215, 169		0. 000000	69.00
70. 00 07000 ELECTROCARD OLOGT	470, 033	2,717,134	3, 213, 10	0.000000	0. 000000	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	57, 385	90, 537	147, 922		0. 000000	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 645	136, 714			0. 000000	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 641, 537	6, 530, 510			0. 000000	73.00
74. 00 07400 RENAL DI ALYSI S	2,041,337	0, 330, 310	7, 172, 04	0. 000000	0. 000000	74.00
75. 00 07500 ASC (NON-DISTINCT PART)		0			0. 000000	75. 00
76. 00 03030 ANGI OCARDI OGRAPHY		0		0.000000	0. 000000	76.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>		1	0.000000	0.000000	70.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	(88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	l ol	0				89. 00
90. 00 09000 CLINI C		0		0. 000000	0. 000000	90.00
91. 00 09100 EMERGENCY	1, 553, 532	13, 331, 921	14, 885, 453		0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	220, 432	139, 017			0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS		•	,			
94.00 09400 HOME PROGRAM DIALYSIS	0	0	(0.000000	0.000000	94.00
95. 00 09500 AMBULANCE SERVICES	o	0		0.000000	0.000000	95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	O	0	(0. 000000	0.000000	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	(0. 000000	0.000000	97. 00
99. 00 09900 CMHC	0	0	(99. 00
99. 10 09910 CORF	o	0	(99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0	(100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	(101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	(105. 00
106.00 10600 HEART ACQUISITION	0	0	(106. 00
107.00 10700 LIVER ACQUISITION	0	0	(107. 00
108.00 10800 LUNG ACQUISITION	0	0	(108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	(109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	(110. 00
111.00 11100 ISLET ACQUISITION	0	0	(111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	(115. 00
116. 00 11600 HOSPI CE	0	0	()		116. 00
200.00 Subtotal (see instructions)	14, 238, 160	64, 897, 819	79, 135, 979	7		200. 00
201.00 Less Observation Beds	14 000 410	/ 4 007 010	70 405 07			201. 00
202.00 Total (see instructions)	14, 238, 160	64, 897, 819	79, 135, 979	7		202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES STARKE MEMORIAL HOSPITAL Provider CCN: 15-0102

			Title XVIII	Hospi tal	5/30/2022 10:09 am PPS
	Cost Center Description	PPS Inpatient	THE XVIII	nospi tui	113
	cost contor social per on	Ratio			
		11.00			
	TIENT ROUTINE SERVICE COST CENTERS				
	ADULTS & PEDIATRICS				30.00
	INTENSIVE CARE UNIT				31.00
	SUBPROVIDER - IPF				40.00
	SUBPROVIDER - IRF				41. 00
	NURSERY LLARY SERVICE COST CENTERS				43. 00
	OPERATING ROOM	0. 265499			50. 00
	RECOVERY ROOM	0. 000000			51. 00
	DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
	ANESTHESI OLOGY	0. 004852			53. 00
	RADI OLOGY-DI AGNOSTI C	0. 321210			54. 00
54. 01 0540	ULTRASOUND	0. 069656			54. 01
55. 00 05500	RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
	RADI OI SOTOPE	0. 142442			56. 00
	CT SCAN	0. 018411			57. 00
58. 00 05800	l control of the cont	0. 050655			58. 00
1	CARDI AC CATHETERI ZATI ON	0.000000			59.00
	LABORATORY	0. 106918			60.00
	WHOLE BLOOD & PACKED RED BLOOD CELL INTRAVENOUS THERAPY	0. 000000 0. 000000			62.00
	RESPI RATORY THERAPY	0. 882961			64. 00 65. 00
	PHYSI CAL THERAPY	0. 332865			66. 00
	OCCUPATIONAL THERAPY	0. 000000			67. 00
	SPEECH PATHOLOGY	0. 000000			68. 00
	ELECTROCARDI OLOGY	0. 084800			69. 00
1	ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
72. 00 07200	IMPL. DEV. CHARGED TO PATIENTS	0. 633098			72. 00
	DRUGS CHARGED TO PATIENTS	0. 156450			73. 00
	RENAL DIALYSIS	0. 000000			74.00
	ASC (NON-DISTINCT PART)	0. 000000			75. 00
	O ANGI OCARDI OGRAPHY	0. 000000			76. 00
	ATIENT SERVICE COST CENTERS RURAL HEALTH CLINIC				88. 00
	FEDERALLY QUALIFIED HEALTH CENTER				89. 00
	CLINIC	0. 000000			90.00
	EMERGENCY	0. 196857			91.00
1	OBSERVATION BEDS (NON-DISTINCT PART	0. 990224			92.00
	R REIMBURSABLE COST CENTERS				
94. 00 09400	HOME PROGRAM DIALYSIS	0. 000000			94. 00
95. 00 09500	AMBULANCE SERVICES	0. 000000			95. 00
1	DURABLE MEDICAL EQUIP-RENTED	0. 000000			96. 00
	DURABLE MEDICAL EQUIP-SOLD	0. 000000			97. 00
	D CMHC				99.00
	CORF				99. 10
	1&R SERVICES-NOT APPRVD PRGM HOME HEALTH AGENCY				100. 00 101. 00
	AL PURPOSE COST CENTERS				101.00
	KIDNEY ACQUISITION				105. 00
1	HEART ACQUISITION				106. 00
	LIVER ACQUISITION				107. 00
108.00 10800	LUNG ACQUISITION				108. 00
	PANCREAS ACQUISITION				109. 00
110. 00 11000	INTESTINAL ACQUISITION				110. 00
	ISLET ACQUISITION				111. 00
	INTEREST EXPENSE				113. 00
	UTILIZATION REVIEW-SNF				114. 00
	AMBULATORY SURGICAL CENTER (D. P.)				115. 00
116. 00 11600	1				116.00
200.00	Subtotal (see instructions)				200. 00 201. 00
201. 00 202. 00	Less Observation Beds Total (see instructions)				201.00
202.00	Total (See Histiactions)	1			1202.00

Health Financial Systems		STARKE MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COMPUT	TATION OF RATIO OF COSTS TO CHARGES			Peri od: Worksheet From 01/01/2021 Part I To 12/31/2021 Date/Time		narod:		
					10 12/31/2021	Date/Time Pre 5/30/2022 10:	09 am	
			Ti tl	e XIX	Hospi tal	PPS	1	
	Cook Cooker Doorsi ati or	T-+-1 C+	Th	T-+-1 C+-	Costs	T-+-1 C+-		
	Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs		
		Part I, col.						
		26)	0.00	0.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00		
30. 00	03000 ADULTS & PEDIATRICS	3, 082, 741		3, 082, 74	1 0	3, 082, 741	30.00	
31. 00	03100 INTENSIVE CARE UNIT	C	l .	(0	0	1 .	
40.00	04000 SUBPROVI DER - I PF)		0	0	40.00	
41. 00	04100 SUBPROVI DER - I RF	C)		0	0		
43. 00	04300 NURSERY)		0 0	0	43. 00	
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	1, 383, 430)	1, 383, 430	0 0	1, 383, 430	50.00	
51. 00	05100 RECOVERY ROOM	1,000,100		1,000,100	o o	0	1	
52.00	05200 DELIVERY ROOM & LABOR ROOM	C		(0	0	52. 00	
53. 00	05300 ANESTHESI OLOGY	5, 866		5, 866		5, 866	1	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 397, 146	l .	1, 397, 140		1, 397, 146	1	
54. 01	05401 ULTRASOUND	152, 038		152, 038	3	152, 038	1	
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	71, 696	<u>'</u>	71, 69	5	0 71, 696		
57. 00	05700 CT SCAN	187, 307		187, 30		187, 307	1	
58. 00	05800 MRI	138, 989	1	138, 989		138, 989		
59. 00	05900 CARDI AC CATHETERI ZATI ON	C			0	0	1	
60.00	06000 LABORATORY	1, 756, 813		1, 756, 813	3 0	1, 756, 813		
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C			0	0	02.00	
64. 00	06400 I NTRAVENOUS THERAPY	(F(043		(5/ 04	0	0	0 00	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	656, 947 1, 004, 769	1	656, 94 ⁻ 1, 004, 76 ⁹		656, 947 1, 004, 769	1	
67. 00	06700 OCCUPATI ONAL THERAPY	1,004,707		1,004,70		1,004,709	67.00	
68. 00	06800 SPEECH PATHOLOGY	C	Ö		0	Ō	1	
69. 00	06900 ELECTROCARDI OLOGY	272, 645	i	272, 64!	5 0	272, 645	69.00	
70. 00	07000 ELECTROENCEPHALOGRAPHY	C)		0	0		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	00.0(1)	00.04	0	0 00 0/1	1	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	88, 861 1, 434, 968	ł	88, 86° 1, 434, 968		88, 861 1, 434, 968	1	
74. 00	07400 RENAL DIALYSIS	1, 434, 700		1, 434, 700		1, 434, 700	1	
75. 00	07500 ASC (NON-DISTINCT PART)	d			0	Ō	75. 00	
76. 00	03030 ANGI OCARDI OGRAPHY	C)	(0	0	76. 00	
00.00	OUTPATIENT SERVICE COST CENTERS	Т .	.I	T.			1 00 00	
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER				0 0	0		
90.00	09000 CLINIC					0	1	
91. 00	09100 EMERGENCY	2, 930, 309		2, 930, 30		2, 930, 309	1	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	355, 935		355, 93!	5	355, 935	92. 00	
04.00	OTHER REIMBURSABLE COST CENTERS		ı	1			0.4.00	
	09400 HOME PROGRAM DI ALYSIS 09500 AMBULANCE SERVICES					0		
	09600 DURABLE MEDICAL EQUIP-RENTED					0	1	
	09700 DURABLE MEDICAL EQUIP-SOLD				o o	Ö	1	
99. 00	09900 CMHC	C			o l	0	1	
	09910 CORF	C			o l	0		
	10000 I &R SERVI CES-NOT APPRVD PRGM	C)		0		100.00	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS)		0	0	101. 00	
105 00	10500 KIDNEY ACQUISITION			(n	105. 00	
	10600 HEART ACQUISITION						106. 00	
107.00	10700 LIVER ACQUISITION				o l		107. 00	
	10800 LUNG ACQUISITION	C			O		108. 00	
	10900 PANCREAS ACQUISITION	C]				109.00	
	11000 INTESTINAL ACQUISITION		(ار		110. 00 111. 00	
	11100 SLET ACQUISITION 11300 NTEREST EXPENSE		Ί				113.00	
	11400 UTILIZATION REVIEW-SNF						114. 00	
	11500 AMBULATORY SURGICAL CENTER (D.P.)		d)	l n	115 00	

14, 920, 460

14, 564, 525

355, 935

14, 920, 460

14, 564, 525

355, 935

0 115.00 0 116.00

14, 920, 460 200. 00 355, 935 201. 00 14, 564, 525 202. 00

201.00

202.00

115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)
116.00 11600 HOSPICE
200.00 Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Health Financial Systems STARKE MEMORIAL				In Lie	Lieu of Form CMS-2552-1	
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co	CN: 15-0102	Peri od: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/30/2022 10:	
		Ti tl	e XIX	Hospi tal	PPS	
	Charges					
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	

				Ti +1	e XIX	Hospi tal	5/30/2022 TO: PPS	09 alli
				Charges	e viv	HOSPI tai	FF3	
		Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
		cost center bescription	Tripati ent	outpatrent	+ col . 7)	Ratio	Inpati ent	
					' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	nati o	Ratio	
			6.00	7. 00	8. 00	9. 00	10.00	
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS	4, 648, 925		4, 648, 925			30.00
31.00		INTENSIVE CARE UNIT	O		0)		31.00
40.00		SUBPROVI DER - I PF	О		0)		40. 00
41.00	04100	SUBPROVIDER - IRF	O		0)		41.00
43.00		NURSERY	0		0			43.00
	ANCI L	LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	116, 013	5, 094, 657	5, 210, 670	0. 265499	0. 000000	50.00
51. 00		RECOVERY ROOM	0	0	0	0. 000000	0. 000000	
52. 00		DELIVERY ROOM & LABOR ROOM	0	0	0	0. 000000	0. 000000	
53. 00		ANESTHESI OLOGY	24, 745	1, 184, 364			0. 000000	
54. 00		RADI OLOGY-DI AGNOSTI C	220, 376	4, 129, 262			0. 000000	
54. 01		ULTRASOUND	98, 114	2, 084, 570	1		0.000000	
55. 00		RADI OLOGY-THERAPEUTI C	0	0			0.000000	
56.00		RADI OI SOTOPE	12, 801	490, 533			0.000000	
57. 00 58. 00	05700	CT SCAN	1, 126, 726	9, 046, 738			0. 000000 0. 000000	
59.00		CARDI AC CATHETERI ZATI ON	130, 126	2, 613, 722	2, 743, 848	0. 050655 0. 000000	0. 000000	
60.00		LABORATORY	2, 084, 656	14, 346, 681	16, 431, 337		0. 000000	
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELL	2,004,030	14, 340, 061	10, 431, 337	0. 000000	0.00000	
64. 00		INTRAVENOUS THERAPY	0	0		0.00000	0. 000000	
65. 00		RESPIRATORY THERAPY	528, 285	215, 742	744, 027		0. 000000	
66. 00		PHYSI CAL THERAPY	272, 827	2, 745, 717			0. 000000	
67. 00		OCCUPATI ONAL THERAPY	272,027	2, 710, 717	_	0. 000000	0. 000000	
68. 00		SPEECH PATHOLOGY	o	0		0. 000000	0. 000000	
69. 00		ELECTROCARDI OLOGY	498, 035	2, 717, 134	3, 215, 169		0. 000000	
70.00		ELECTROENCEPHALOGRAPHY	0	0	0	0. 000000	0. 000000	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	57, 385	90, 537	147, 922	0.000000	0. 000000	71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3, 645	136, 714	140, 359	0. 633098	0. 000000	72. 00
73.00		DRUGS CHARGED TO PATIENTS	2, 641, 537	6, 530, 510	9, 172, 047	0. 156450	0. 000000	73. 00
74.00		RENAL DIALYSIS	0	0	0		0. 000000	
75. 00		ASC (NON-DISTINCT PART)	0	0			0. 000000	
76. 00		ANGI OCARDI OGRAPHY	0	0	0	0. 000000	0. 000000	76. 00
00.00		TIENT SERVICE COST CENTERS				0.00000	0.00000	00.00
88. 00 89. 00		RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0		0. 000000 0. 000000	0. 000000 0. 000000	
90.00		CLINIC	0	0		0.00000	0. 000000	
91.00		EMERGENCY	1, 553, 532	13, 331, 921	1		0.000000	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	220, 432	13, 331, 721			0.00000	
,2.00		REI MBURSABLE COST CENTERS	2207 102	1077017	0077117	0.770221	0.00000	72.00
94.00		HOME PROGRAM DIALYSIS	0	0	0	0.000000	0. 000000	94. 00
95.00	09500	AMBULANCE SERVICES	o	0	0	0.000000	0. 000000	95. 00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0. 000000	96. 00
97. 00	1	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0. 000000	0. 000000	97. 00
99. 00	09900		0	0	0)		99. 00
			0	0	0			99. 10
		I &R SERVICES-NOT APPRVD PRGM	0	0				100.00
101.00		HOME HEALTH AGENCY	0	0	0)		101. 00
105.00		AL PURPOSE COST CENTERS KIDNEY ACQUISITION						105 00
	1	HEART ACQUISITION	0	0				105. 00 106. 00
		LIVER ACQUISITION	0	0				107. 00
	1	LUNG ACQUISITION	0	0				107. 00
		PANCREAS ACQUISITION		0				109.00
	1	INTESTINAL ACQUISITION	ا	0	١			110. 00
	1	ISLET ACQUISITION		0	ا م			111.00
		INTEREST EXPENSE		· ·				113. 00
		UTI LI ZATI ON REVI EW-SNF						114. 00
		AMBULATORY SURGICAL CENTER (D. P.)	o	0	0			115. 00
116.00	11600	HOSPI CE	0	0	0			116. 00
200.00	1	Subtotal (see instructions)	14, 238, 160	64, 897, 819	79, 135, 979			200. 00
201.00	1	Less Observation Beds						201. 00
202.00)	Total (see instructions)	14, 238, 160	64, 897, 819	79, 135, 979	1		202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES STARKE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0102

Peri od: Worksheet C
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared: 5/30/2022 10:09 am

			Title XIX	Hospi tal	PPS	9 alli
	Cost Center Description	PPS Inpatient	THE XIX	nospi tui	110	
		Ratio				
		11.00				
I	NPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.00
	03100 INTENSIVE CARE UNIT					31.00
	04000 SUBPROVI DER - I PF				1	40. 00
1	04100 SUBPROVI DER – I RF					41.00
	04300 NURSERY					43.00
	NCI LLARY SERVI CE COST CENTERS	0.245400				EO 00
	D5000 OPERATING ROOM D5100 RECOVERY ROOM	0. 265499 0. 000000				50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				51. 00 52. 00
	05300 ANESTHESI OLOGY	0. 004852			I	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0. 321210			I	54. 00
	05401 ULTRASOUND	0. 069656			I	54. 01
	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55. 00
	05600 RADI OI SOTOPE	0. 142442				56.00
	05700 CT SCAN	0. 018411				57.00
58.00	05800 MRI	0. 050655				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
60.00	06000 LABORATORY	0. 106918				60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000				62.00
1	06400 INTRAVENOUS THERAPY	0. 000000				64.00
1	06500 RESPI RATORY THERAPY	0. 882961				65. 00
1	06600 PHYSI CAL THERAPY	0. 332865				66. 00
	06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
	06800 SPEECH PATHOLOGY	0.000000				68. 00
	06900 ELECTROCARDI OLOGY	0. 084800				69. 00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000 0. 000000				70. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 633098			1	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 156450				73. 00
	07400 RENAL DIALYSIS	0. 000000				74. 00
1	07500 ASC (NON-DISTINCT PART)	0. 000000				75. 00
	03030 ANGI OCARDI OGRAPHY	0. 000000				76.00
C	OUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC	0. 000000				88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89. 00
	09000 CLI NI C	0. 000000			I	90.00
	09100 EMERGENCY	0. 196857			I	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 990224				92. 00
	OTHER REIMBURSABLE COST CENTERS	0.000000				04.00
	09400 HOME PROGRAM DIALYSIS	0.000000				94.00
1	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000 0. 000000				95. 00 96. 00
1	097000 DURABLE MEDICAL EQUIP-SOLD	0. 000000				97. 00
	09900 CMHC	0.000000				99. 00
	09910 CORF					99. 10
1	0000 I&R SERVICES-NOT APPRVD PRGM				1	100. 00
	0100 HOME HEALTH AGENCY					101. 00
	PECIAL PURPOSE COST CENTERS					
105.00	0500 KIDNEY ACQUISITION				I	105. 00
	0600 HEART ACQUISITION					106. 00
1	0700 LIVER ACQUISITION					107. 00
	0800 LUNG ACQUISITION					108. 00
	0900 PANCREAS ACQUISITION					109. 00
1	1000 INTESTINAL ACQUISITION					110.00
	1100 SLET ACQUISITION					111. 00
	1300 INTEREST EXPENSE					113.00
	1400 UTILIZATION REVIEW-SNF 1500 AMBULATORY SURGICAL CENTER (D.P.)					114. 00 115. 00
- 1	11600 HOSPI CE					116. 00
200.00	Subtotal (see instructions)					200. 00
201. 00	Less Observation Beds					201.00
202.00	Total (see instructions)					202.00
	, (1			Į-	

Health Financial Systems

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | In Lieu of Form CMS-2552-10 | Peri od: | Worksheet C | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | From 2002 10 Peri od: | Peri od Provi der CCN: 15-0102

					10	12/31/2021	5/30/2022 10:	
				Ti tl	e XIX	Hospi tal	PPS	
		Cost Center Description	Total Cost		Operating Cost		Operating Cost	
					Net of Capital	Reduction	Reduction	
			I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
			1.00	2.00	col . 2) 3.00	4. 00	5. 00	
	ANCLL	LARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00		OPERATING ROOM	1, 383, 430	106, 503	1, 276, 927	0	0	50.00
51. 00		RECOVERY ROOM	0	0		0	o o	51. 00
52.00	1	DELIVERY ROOM & LABOR ROOM	0	l o	0	0	0	52.00
53.00		ANESTHESI OLOGY	5, 866	171	5, 695	0	0	53. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	1, 397, 146	47, 831	1, 349, 315	0	0	54.00
54. 01		ULTRASOUND	152, 038	848	151, 190	0	0	54. 01
55. 00		RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
56. 00	1	RADI OI SOTOPE	71, 696			0	0	56. 00
57. 00		CT SCAN	187, 307	7, 819		0	0	57. 00
58. 00	05800		138, 989	15, 471	123, 518	0	0	58. 00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	1 754 012	24 044	1 710 947	0	0	59. 00 60. 00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELL	1, 756, 813	36, 946	1, 719, 867	0	0	62.00
64. 00	1	INTRAVENOUS THERAPY	0			0	0	64. 00
65. 00	1	RESPI RATORY THERAPY	656, 947	12, 570	644, 377	0	o o	65. 00
66. 00	1	PHYSI CAL THERAPY	1, 004, 769			0	Ō	66. 00
67. 00	1	OCCUPATI ONAL THERAPY	0	C	0	0	0	67. 00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00		ELECTROCARDI OLOGY	272, 645	6, 562	266, 083	0	0	69. 00
70. 00		ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	951		0	0	71. 00
72.00	1	IMPL. DEV. CHARGED TO PATIENTS	88, 861	1, 430		0	0	72.00
73.00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	1, 434, 968			0	0	73. 00 74. 00
74. 00 75. 00		ASC (NON-DISTINCT PART)	0	0	1	0		75.00
76. 00		ANGI OCARDI OGRAPHY	0		1	0	0	76.00
		TIENT SERVICE COST CENTERS	-	_	-			
88. 00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	C	0	0	0	89. 00
90.00	1	CLINIC	0	0	0	0	0	90. 00
91.00		EMERGENCY	2, 930, 309			0	0	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS	355, 935	14, 435	341, 500	0	0	92. 00
94. 00		HOME PROGRAM DIALYSIS	1	0	0	0	0	94. 00
95. 00		AMBULANCE SERVICES	0			0	0	95. 00
96. 00		DURABLE MEDICAL EQUIP-RENTED	0	Ö	0	0	Ō	96. 00
97.00		DURABLE MEDICAL EQUIP-SOLD	0	O	0	0	0	97. 00
99. 00	09900	СМНС	0	0	0	0	0	99. 00
99. 10	09910	l e e e e e e e e e e e e e e e e e e e	0	0	0	0	0	99. 10
		I &R SERVICES-NOT APPRVD PRGM	0	0	1	0	l	100. 00
101.00		HOME HEALTH AGENCY	0	0	0	0	0	101. 00
105 00		AL PURPOSE COST CENTERS	0		J O	0		105 00
		KIDNEY ACQUISITION HEART ACQUISITION	0			0		105. 00 106. 00
		LIVER ACQUISITION	0			0		107. 00
		LUNG ACQUISITION	0		0	0		108. 00
		PANCREAS ACQUISITION	0	l o	0	0		109. 00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
	1	ISLET ACQUISITION	0	C	0	0	0	111. 00
		I NTEREST EXPENSE						113. 00
	1	UTILIZATION REVIEW-SNF				-		114.00
		AMBULATORY SURGICAL CENTER (D. P.)	0			0		115. 00 116. 00
200.00		HOSPICE Subtotal (sum of lines 50 thru 199)	11, 837, 719	361, 653	11, 476, 066	0		200. 00
200.00	1	Less Observation Beds	355, 935			0		200.00
202.00		Total (line 200 minus line 201)	11, 481, 784			0		202. 00

Provider CCN: 15-0102

| In Lieu of Form CMS-2552-10 | Worksheet C | Part II | B1/2021 | Date/Time Prepared: 5/30/2022 10:09 am

		Ti tl	e XIX	Hospi tal	PPS	07 diii
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
real control of the c	Capital and	(Worksheet C.	Cost to Charge			
		Part I, column				
	Reduction	8)	/ col . 7)			
	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 383, 430	5, 210, 670	0. 265499			50.00
51.00 05100 RECOVERY ROOM	0	0	0.000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000			52.00
53. 00 05300 ANESTHESI OLOGY	5, 866	1, 209, 109	0. 004852			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 397, 146	4, 349, 638	0. 321210			54.00
54. 01 05401 ULTRASOUND	152, 038					54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C			0.000000			55.00
56. 00 05600 RADI 0I SOTOPE	71, 696	503, 334				56.00
57. 00 05700 CT SCAN	187, 307					57.00
58. 00 05800 MRI	138, 989					58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.000000			59.00
60. 00 06000 LABORATORY	1, 756, 813	16, 431, 337				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1,100,010	0	0. 000000			62. 00
64. 00 06400 I NTRAVENOUS THERAPY			0. 000000			64. 00
65. 00 06500 RESPIRATORY THERAPY	656, 947	1	0. 882961			65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 004, 769	1	0. 332865			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1,004,707	1				67. 00
68. 00 06800 SPEECH PATHOLOGY			0.000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	272, 645	3, 215, 169				69. 00
70. 00 07000 ELECTROCARD OLOGT	272,043	3,213,109	0.000000			70.00
		147 022				71.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	· · · · · ·	147, 922				
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	88, 861	1				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 434, 968	1				73.00
74. 00 07400 RENAL DIALYSIS	0		0.000000			74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0		0.000000			75. 00
76. 00 03030 ANGI OCARDI OGRAPHY	0	0	0.000000			76. 00
OUTPATIENT SERVICE COST CENTERS			0.000000			
88. 00 08800 RURAL HEALTH CLINIC	0	1	0.000000			88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1	0.000000			89. 00
90. 00 09000 CLI NI C	0	1	0.000000			90.00
91. 00 09100 EMERGENCY	2, 930, 309					91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	355, 935	359, 449	0. 990224			92. 00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S	0					94.00
95. 00 09500 AMBULANCE SERVI CES	0	0	0. 000000			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 000000			96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0. 000000			97. 00
99. 00 09900 CMHC	0	0	0. 000000			99. 00
99. 10 09910 CORF	0	_	0. 000000			99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	l .				100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0. 000000			101. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	0	1				105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	1				106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0					107. 00
108.00 10800 LUNG ACQUISITION	0	1				108. 00
109.00 10900 PANCREAS ACQUISITION	0					109. 00
110.00 11000 INTESTINAL ACQUISITION	0	_				110. 00
111.00 11100 ISLET ACQUISITION	0	0	0.000000			111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0				115. 00
116. 00 11600 HOSPI CE	0	0	0.000000			116. 00
200.00 Subtotal (sum of lines 50 thru 199)	11, 837, 719					200. 00
201.00 Less Observation Beds	355, 935					201. 00
202.00 Total (line 200 minus line 201)	11, 481, 784	74, 487, 054				202. 00

Heal th	Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Pre 5/30/2022 10:0	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
		Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
		(from Wkst. B,		Related Cost			
		Part II, col.		(col . 1 - col			
		26)		2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDI ATRI CS	125, 023	0	125, 02	2, 018		
31.00	INTENSIVE CARE UNIT	0			0	0. 00	31. 00
40.00	SUBPROVI DER - I PF	0	0		0	0. 00	40. 00
41.00	SUBPROVI DER - I RF	0	0		0	0.00	41. 00
43.00	NURSERY	0			0	0.00	43.00
200.00	Total (lines 30 through 199)	125, 023		125, 02	2, 018		200. 00
	Cost Center Description	I npati ent	I npati ent				
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
			6)				
		6. 00	7. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	674	41, 754				30. 00
31.00	INTENSIVE CARE UNIT	0	0				31. 00
40.00	SUBPROVIDER - IPF	0	0				40. 00
41.00	SUBPROVI DER - I RF	0	0				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	674	41, 754				200. 00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/30/2022 10:	pared:
		Ti tl e	e XVIII	Hospi tal	973072022 TO: PPS	09 alli
Cost Center Description	Capi tal		Ratio of Cost		Capital Costs	
p	Related Cost			Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col		column 4)	
	Part II, col.	8)	2)		ŕ	
	26)	,	,			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	106, 503	5, 210, 670	0. 02043	9 55, 047	1, 125	50.00
51. 00 05100 RECOVERY ROOM	0	C	0.00000	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C	0.00000	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	171	1, 209, 109	0.00014	1 9, 465	1	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	47, 831	4, 349, 638	0. 01099	7 80, 513	885	54.00
54. 01 05401 ULTRASOUND	848	2, 182, 684	0.00038	9 36, 143	14	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	l c	0.00000	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	500	503, 334	0.00099	3 0	0	56. 00
57. 00 05700 CT SCAN	7, 819	10, 173, 464	0.00076	9 464, 519	357	57. 00
58. 00 05800 MRI	15, 471	2, 743, 848	0.00563	54, 691	308	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C	0.00000	0	0	59. 00
60. 00 06000 LABORATORY	36, 946	16, 431, 337			1, 740	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0. 00000	0 0	0	62.00
64. 00 06400 INTRAVENOUS THERAPY	0		0. 00000	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	12, 570	744, 027	1		2, 217	1
66. 00 06600 PHYSI CAL THERAPY	29, 074		•		1, 174	1
67. 00 06700 OCCUPATI ONAL THERAPY	0	0,010,01	0. 00000	•	0	
68. 00 06800 SPEECH PATHOLOGY	0	d	0. 00000		0	
69. 00 06900 ELECTROCARDI OLOGY	6, 562	3, 215, 169	1		416	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0.00000	•	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	l c	0. 00000		0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 430	140, 359	•		12	
73. 00 07300 DRUGS CHARGED TO PATIENTS	16, 703		•		1, 494	1
74. 00 07400 RENAL DIALYSIS	0	7,1,2,01,	0.00000	•	0	
75. 00 07500 ASC (NON-DISTINCT PART)	Ö		1		0	
76. 00 03030 ANGI OCARDI OGRAPHY	0				0	
OUTPATIENT SERVICE COST CENTERS			0.0000	<u> </u>		7 0. 00
88. 00 08800 RURAL HEALTH CLINIC	0	C	0.00000	0 0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	Ö	_	1		Ö	
90. 00 09000 CLINIC	0		0. 00000		Ö	
91. 00 09100 EMERGENCY	63, 839	_	1		2, 533	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	14, 435		1	•	4, 544	
OTHER REIMBURSABLE COST CENTERS	1 17 100	0077117	0.0.0.0	, 1.0, 100	.,	72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	1 0	(0.00000	0 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES			1		Ĭ	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0		0. 00000	ol o	0	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	1 0	ľ	0.00000		0	
200.00 Total (lines 50 through 199)	360, 702	74, 339, 132	•	3, 456, 117	_	200.00
233. 33 ₁ 10tal (11103 33 till 34gh 177)	1 000, 702	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	1	0, 100, 117	10,020	1-30.00

Health Financial Systems	STARKE MEMORIA	L HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COSTS			Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre 5/30/2022 10:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adjustments	Nursi ng Program	Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - PF	0 0	0 0 0	1	0 0 0 0	0	31. 00 40. 00
41.00 04100 SUBPROVIDER - RF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0 0	0 0 0		0 0 0 0	0 0 0	
Cost Center Description	Amount (see	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	0 0	0 0 0 0	_,	0 0.00 0 0.00 0 0.00	0 0	31. 00 40. 00 41. 00
43. 00 04300 NURSERY		0	1	0.00		
200.00 Total (lines 30 through 199) Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	0	2, 01	8	674	200. 00
30. 00	0 0 0 0 0					30. 00 31. 00 40. 00 41. 00 43. 00 200. 00

| Peri od: | Worksheet D | From 01/01/2021 | Part IV | To | 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0102 THROUGH COSTS

					To 12/31/2021	Date/Time Pre 5/30/2022 10:	
-			Ti tl e	e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
	ANOULLARY CERVICE COCT CENTERS	1.00	2A	2. 00	3A	3. 00	
EO 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM			,	0 (FO 00
50. 00 51. 00	05100 RECOVERY ROOM	0	C	•	0	-	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0					52.00
53. 00	05300 ANESTHESI OLOGY						53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C						54.00
54. 01	05401 ULTRASOUND						
55. 00	05500 RADI OLOGY-THERAPEUTI C		Č		0		55. 00
56. 00	05600 RADI OI SOTOPE		C		0	ol o	56. 00
57. 00	05700 CT SCAN	l ol	C		0	ol o	57. 00
58. 00	05800 MRI	l ol	C		0	ol o	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	O	C		0	ol o	59.00
60.00	06000 LABORATORY	o	C		0	ol o	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	C		0	ol o	62.00
64.00	06400 I NTRAVENOUS THERAPY	o	C		0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	o	C		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	C		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	C		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	C		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	C)	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	C		0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	C		0	0	
74. 00	07400 RENAL DI ALYSI S	0	C)	0	0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	C	1	0	0	75. 00
76. 00	03030 ANGI OCARDI OGRAPHY	0	C)	0 (0	76. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	C	\	0 (o lo	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	1			89.00
90.00	09000 CLINIC						90.00
91. 00	09100 EMERGENCY					-	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			1	Ö		92.00
72.00	OTHER REIMBURSABLE COST CENTERS	١		1			72.00
94. 00	09400 HOME PROGRAM DIALYSIS	0	C)	0 (0	94. 00
95. 00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0	0	96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	o	C		0	0	97. 00
200.00	Total (lines 50 through 199)	0	C)	0	0 0	200. 00

Health Financial Systems	STARKE MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0102	Peri od:	Worksheet D

From 01/01/2021 Part IV
To 12/31/2021 Date/Time Prepared: THROUGH COSTS 5/30/2022 10:09 am Title XVIII Hospi tal All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 5, 210, 670 0.000000 50.00 000000000000000000000000000 51.00 05100 RECOVERY ROOM 0 0 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0.000000 52.00 05300 ANESTHESI OLOGY 0 0 1, 209, 109 53 00 0.000000 53 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 0 4, 349, 638 0.000000 54.00 54.01 05401 ULTRASOUND 2, 182, 684 0.000000 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0.000000 55 00 05600 RADI OI SOTOPE 0 56.00 0 503, 334 0.000000 56.00 57.00 05700 CT SCAN 10, 173, 464 0.000000 57.00 05800 MRI 58.00 2, 743, 848 0.000000 58.00 05900 CARDIAC CATHETERIZATION 0 0.000000 59 00 59 00 60.00 06000 LABORATORY 16, 431, 337 0.000000 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 62.00 62.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0 744, 027 0.000000 65 00 66.00 06600 PHYSI CAL THERAPY 0 3, 018, 544 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 0 0.000000 69.00 3, 215, 169 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0.000000 71.00 147, 922 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 140, 359 72.00 0 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0 9, 172, 047 0.000000 73.00 Ω 73 00 74.00 07400 RENAL DIALYSIS 0 0 0.000000 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 0.000000 75.00 76.00 03030 ANGI OCARDI OGRAPHY 0 0 0 0.000000 76.00 0 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 0.000000 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0.000000 89.00 0 0 90.00 09000 CLINIC 0 90.00 0.000000 91.00 09100 EMERGENCY 0 14, 885, 453 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 0 0 359, 449 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 O 0.000000 94.00 95.00 09500 AMBULANCE SERVICES 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0.000000 96.00 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0.000000 97.00

0

74, 487, 054

200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	STARKE MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0102	Peri od:	Worksheet D

From 01/01/2021 Part IV THROUGH COSTS 12/31/2021 Date/Time Prepared: 5/30/2022 10:09 am Title XVIII Hospi tal PPS Outpati ent Cost Center Description Outpati ent Inpatient Inpati ent Outpati ent Program Ratio of Cost Program Program Program Pass-Through to Charges Pass-Through Charges Charges Costs (col. $(col. 6 \div col$ Costs (col. x col. 12) 13.00 7) x col. 10) 9.00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 0.000000 55, 047 50.00 1, 666, 587 0 0 51.00 05100 RECOVERY ROOM 0.000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52.00 0 52.00 05300 ANESTHESI OLOGY 0.000000 9, 465 365, 393 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.000000 80, 513 703, 140 54.00 0 54.01 05401 ULTRASOUND 0.000000 36, 143 0 362, 124 0 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 05600 RADI OI SOTOPE 0.000000 0 169, 130 56 00 0 56 00 05700 CT SCAN 0 57.00 0.000000 464, 519 2, 255, 136 0 57.00 58.00 05800 MRI 0.000000 54, 691 668, 547 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0.000000 0 0 59.00 06000 LABORATORY 773, 696 1, 591, 705 0.000000 0 60 00 60 00 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0 0 62.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 0 64.00 06500 RESPIRATORY THERAPY 36, 237 65 00 0.000000 131 198 0 65 00 66.00 06600 PHYSI CAL THERAPY 0.000000 121, 889 1, 663 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 0.000000 68.00 0 0 06900 ELECTROCARDI OLOGY 203, 740 0.000000 759, 456 69 00 69 00 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 50,004 55, 301 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 1, 215 0 83, 956 0 72.00 07300 DRUGS CHARGED TO PATIENTS 820, 347 0.000000 0 2, 386, 974 73.00 73.00 0 74.00 07400 RENAL DIALYSIS 0.000000 0 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 0 75.00 75.00 03030 ANGI OCARDI OGRAPHY 0 76.00 0.000000 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0.000000 0 0 89.00 90.00 09000 CLI NI C 0.000000 0 0 90.00 0 0 09100 EMERGENCY 590, 516 91.00 0.000000 2.448.401 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 0 92.00 92.00 113, 138 87,652 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 0.000000 94.00 94.00 0 0 09500 AMBULANCE SERVICES 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 97.00

0

13, 641, 402

0 200.00

3, 506, 121

200.00

Total (lines 50 through 199)

	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/30/2022 10:	nared:
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
	T	1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	T		T	_1		
50. 00	05000 OPERATING ROOM	0. 265499			0		50. 00
51.00	05100 RECOVERY ROOM	0. 000000			0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0. 004852	1		0	.,	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 321210			0	220,000	1
54. 01	05401 ULTRASOUND	0. 069656		1	0	25, 224	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000		•	0	1	55. 00
56.00	05600 RADI OI SOTOPE	0. 142442			0	24, 091	56. 00
57. 00	05700 CT SCAN	0. 018411			0	41, 519	
58. 00	05800 MRI	0. 050655	668, 547		0	33, 865	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59. 00
60.00	06000 LABORATORY	0. 106918	1, 591, 705		0	170, 182	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0		0	0	62.00
64.00	06400 I NTRAVENOUS THERAPY	0.000000	0		0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 882961	36, 237		0	31, 996	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 332865	1, 663		0 0	554	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 084800	759, 456		0 0	64, 402	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	55, 301		0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 633098	83, 956		0	53, 152	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 156450	2, 386, 974		0 11, 774	373, 442	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	0		0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	75. 00
76.00	03030 ANGI OCARDI OGRAPHY	0. 000000	0		0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						1
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90.00	09000 CLI NI C	0. 000000	0		0	0	90.00
91.00	09100 EMERGENCY	0. 196857	2, 448, 401		0	481, 985	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 990224	87, 652		0	86, 795	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0.000000)		0 0		94. 00
95.00	09500 AMBULANCE SERVICES	0. 000000)		0		95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0	0	97.00
200.00	Subtotal (see instructions)		13, 641, 402		0 11, 774	2, 057, 313	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		13, 641, 402		0 11, 774	2, 057, 313	202. 00

In Lieu of Form CMS-2552-10 Health Financial Systems STARKE MEMORIAL HOSPITAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0102 Peri od: Worksheet D From 01/01/2021 Part V Date/Time Prepared: 12/31/2021 5/30/2022 10:09 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed 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 0 50.00 51.00 05100 RECOVERY ROOM 00000000000000000000000000 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 05300 ANESTHESI OLOGY 53.00 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54. 01 05401 ULTRASOUND 0 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 56. 00 05600 RADI 0I SOTOPE 0 56.00 05700 CT SCAN 0 57.00 57.00 05800 MRI 0 58 00 58 00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 60.00 06000 LABORATORY 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 06400 I NTRAVENOUS THERAPY 0 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 Ω 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,842 73.00 07400 RENAL DIALYSIS 74.00 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 03030 ANGI OCARDI OGRAPHY 76.00 0 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLI NI C 0 0 90.00 09100 EMERGENCY 0 0 91.00 91.00

0

00000

0

0

1,842

1,842

92.00

94.00

95.00

96.00

97.00

200.00

201.00

202.00

92.00

94.00

95.00

96.00

97.00

200.00

201.00

202.00

09200 OBSERVATION BEDS (NON-DISTINCT PART

OTHER REIMBURSABLE COST CENTERS

09600 DURABLE MEDICAL EQUIP-RENTED

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

09700 DURABLE MEDICAL EQUIP-SOLD

09400 HOME PROGRAM DIALYSIS

09500 AMBULANCE SERVICES

Only Charges

Heal th	Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co	<u> </u>	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Pre 5/30/2022 10:	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
		Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
		(from Wkst. B,		Related Cost			
		Part II, col.		(col. 1 - col.			
		26)		2)			
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		,				
30.00	ADULTS & PEDIATRICS	125, 023	0	125, 02	2, 018		1
31.00	INTENSIVE CARE UNIT	0			0	0.00	31. 00
40.00	SUBPROVI DER - I PF	0	0		0	0.00	40. 00
41.00	SUBPROVI DER - I RF	0	0		0	0.00	41. 00
43.00	NURSERY	0			0	0.00	43.00
200.00	Total (lines 30 through 199)	125, 023		125, 02	2, 018		200. 00
	Cost Center Description	I npati ent	I npati ent				
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
			6)				
		6. 00	7. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	32	1, 982				30.00
31.00	INTENSIVE CARE UNIT	0	0				31. 00
40.00	SUBPROVI DER - I PF	0	0				40. 00
41.00	SUBPROVIDER - IRF	0	0				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	32	1, 982				200. 00

Heal th	n Financial Systems	STARKE MEMORI	AL_HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPOR ⁻	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0102	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/30/2022 10:	pared:
			Ti tl	e XIX	Hospi tal	PPS	U9 alli
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col		column 4)	
		Part II, col.	8)	2)		,	
		26)	Í				
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	106, 503	5, 210, 670	0. 02043	19 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0. 00000	0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0. 00000	0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	171	1, 209, 109	0. 00014	1 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	47, 831	4, 349, 638	0. 01099	3, 951	43	54.00
54. 01	05401 ULTRASOUND	848	2, 182, 684	1		1	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0		1		1	1
56. 00	05600 RADI OI SOTOPE	500	503, 334			0	56.00
57. 00	05700 CT SCAN	7, 819				20	
58. 00	05800 MRI	15, 471	2, 743, 848		· ·	21	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	2,7.10,010	0.00000		0	1
60. 00	06000 LABORATORY	36, 946	16, 431, 337				
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	00,710	10, 101, 007	0.00000	· ·	l	
64. 00	06400 I NTRAVENOUS THERAPY		l o	0.00000		0	1
65. 00	06500 RESPIRATORY THERAPY	12, 570	744, 027			ľ	1
66. 00	06600 PHYSI CAL THERAPY	29, 074	3, 018, 544			l	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	27,074	3,010,344	0.00000		l	
68. 00	06800 SPEECH PATHOLOGY	0		0.00000		·	
69. 00	06900 ELECTROCARDI OLOGY	6, 562	3, 215, 169	1		1	1
70.00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	0, 302	3, 213, 107	0.00202		0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0.00000		·	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 430	140, 359	1		0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	16, 703	9, 172, 047			l ~	1
74.00		10, 703	9, 172, 047	0.00182		143	
75. 00			1 0	0.00000		·	
76. 00	07500 ASC (NON-DISTINCT PART)	0		•			1
76.00	03030 ANGLOCARDLOGRAPHY OUTPATLENT SERVICE COST CENTERS	1 0	0	0.00000	0	0	76.00
88. 00		1 0		0.00000	0	0	88. 00
89.00		0		1		ľ	00.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	1	0	1		1	
90.00	09000 CLINIC	0	14 005 453	0.00000		0	
91.00	09100 EMERGENCY	63, 839				•	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	14, 435	359, 449	0. 04015	4, 500	181	92.00
04.00	OTHER REIMBURSABLE COST CENTERS	1 0		0.0000	20		04.00
94.00	09400 HOME PROGRAM DI ALYSI S	0		0.00000	00 0	0	
95. 00			_	0.0000	20	_	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0.00000		0	
97. 00		0 700	74 220 422	0.00000		0	1 , , , , , ,
200.00	Total (lines 50 through 199)	360, 702	74, 339, 132	1	219, 528	J 840	200. 00

Health Financial Systems	STARKE MEMORIA				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST			Period: From 01/01/2021 To 12/31/2021	Date/Time Pre 5/30/2022 10:	pared: 09 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Healt Post-Stepdow Adjustments	h Allied Health n Cost	All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	0 0	0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0	31. 00 40. 00
43. 00 04300 NURSERY 200. 00 Total (lines 30 through 199) Cost Center Description	0 0 0 Swi ng-Bed	0 0 Total Costs	Tatal Dation	0 0 0 0 t Per Diem (col.	o	
cost center bescription	Adjustment Amount (see	(sum of cols. 1 through 3, minus col. 4)	Days	5 ÷ col . 6)	Program Days	
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	2, 01			
31. 00 03100 INTENSIVE CARE UNIT		0	1	0.00		
40. 00 04000 SUBPROVI DER - PF	0	0	1	0.00	•	
41. 00 04100 SUBPROVI DER - RF	U	0	1	0.00		
43. 00 04300 NURSERY		0	l .	0.00	•	
200.00 Total (lines 30 through 199) Cost Center Description	Inpati ent	0	2, 0	8	32	200. 00
COST CENTER DESCRIPTION	Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF	0 0 0					30. 00 31. 00 40. 00
41. 00 04100 SUBPROVI DER - RF	0					41.00
43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0					43. 00 200. 00

| Peri od: | Worksheet D | From 01/01/2021 | Part IV | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | THROUGH COSTS

					10	12/31/2021	5/30/2022 10:	
			Ti tl	e XIX		Hospi tal	PPS	07 diii
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Α		Allied Health	
	·	Anesthetist	Program	Program	Р	ost-Stepdown		
		Cost	Post-Stepdown			Adjustments		
			Adjustments					
		1.00	2A	2. 00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	, , ,						
50.00	05000 OPERATI NG ROOM	0	0		0	0	0	50. 00
51. 00	05100 RECOVERY ROOM	0	0		0	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
54. 01	05401 ULTRASOUND	0	0		0	0	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0		0	0	0	56. 00
57. 00	05700 CT SCAN	0	0		0	0	0	57. 00
58. 00	05800 MRI	0	0		0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59. 00
60.00	06000 LABORATORY	0	0		0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	0	62.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0		0	0	0	65. 00
66.00		0	0		0	0	0	66. 00 67. 00
67. 00	06700 OCCUPATIONAL THERAPY	0	0		0	0	0	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0		0	0	0	68. 00 69. 00
70.00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY		0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	70.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	71.00
72.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
74. 00	07400 RENAL DIALYSIS	0	0		0	0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0	0	0	75.00
76. 00	03030 ANGI OCARDI OGRAPHY		0	•	0	0	0	76.00
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	1	- 0	0	0	70.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	1	0	0	0	89. 00
90.00	09000 CLINIC		0		0	0	0	90.00
91. 00	09100 EMERGENCY		0		0	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	o	_		0	_	0	92. 00
	OTHER REIMBURSABLE COST CENTERS	-1						
94.00	09400 HOME PROGRAM DIALYSIS	0	0		0	0	0	94.00
95.00	09500 AMBULANCE SERVICES							95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	0	96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	o	0		0	0	0	97. 00
200.00	Total (lines 50 through 199)	0	0		0	0	0	200. 00

| Period: | Worksheet D | From 01/01/2021 | Part IV | To | 12/31/2021 | Date/Time Prepared: Provi der CCN: 15-0102 THROUGH COSTS

11111001	30010			Τ	o 12/31/2021	Date/Time Pre 5/30/2022 10:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
	ANOLLI ADV. CEDVI OF COCT. CENTEDO	4.00	5. 00	6. 00	7. 00	8. 00	
FO 00	ANCILLARY SERVICE COST CENTERS	O			F 210 (70	0.000000	
50.00		-1	0			0.000000	1
51.00		0	0		0	0.000000	1
52.00		0	0			0.000000	
53.00		0	0		1, 209, 109	1	1
54.00		0	0		4, 349, 638	l	•
54. 01	05401 ULTRASOUND	0	0		2, 182, 684	l	ı
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0.000000	1
56. 00	05600 RADI OI SOTOPE	0	0	`		0.000000	
57. 00	05700 CT SCAN	0	0	C		0.000000	•
58. 00		0	0	1		l	•
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(1	0.000000	•
60. 00	06000 LABORATORY	0	0	C	16, 431, 337	0.000000	•
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0.000000	•
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0.000000	•
65. 00	06500 RESPI RATORY THERAPY	0	0		744, 027	0.000000	1
66. 00	06600 PHYSI CAL THERAPY	0	0		3, 018, 544	0.000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0.000000	•
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0.000000	1
69. 00	06900 ELECTROCARDI OLOGY	0	0		3, 215, 169	0.000000	•
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0.000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		147, 922	0.000000	•
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		140, 359	0.000000	•
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	(9, 172, 047	0.000000	1
74.00	07400 RENAL DI ALYSI S	0	0	(0	0. 000000	1
75. 00	07500 ASC (NON-DISTINCT PART)	0	0			0. 000000	1
76. 00	03030 ANGI OCARDI OGRAPHY	0	0	C	0	0. 000000	76. 00
	OUTPATIENT SERVICE COST CENTERS	1		1			
88. 00	08800 RURAL HEALTH CLINIC	0	0		-	0.000000	1
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		1	0.000000	•
90. 00	09000 CLI NI C	0	0	1	_	0.000000	90.00
91. 00	09100 EMERGENCY	0	0				•
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(359, 449	0. 000000	92. 00
04.00	OTHER REIMBURSABLE COST CENTERS					0.00000	04.00
94.00		0	0	C	0	0.000000	94.00
95. 00			_			0.000000	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0			0.000000	1
97. 00	•		0			0.000000	•
200.00	O Total (lines 50 through 199)	ı o	0	(74, 487, 054	I	200. 00

Health Financial Systems	STARKE MEMORIAL HOSPITAL	In Lie	eu of Form CMS-2552-10
ADDODTIONMENT OF INDATIENT/OUTDATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-010	Pari ad:	Workshoot D

From 01/01/2021 Part IV THROUGH COSTS 12/31/2021 Date/Time Prepared: 5/30/2022 10:09 am Title XIX Hospi tal PPS Outpati ent Cost Center Description Outpati ent Inpatient Inpati ent Outpati ent Program Ratio of Cost Program Program Program Pass-Through to Charges Pass-Through Charges Charges Costs (col. (col. 6 ÷ col Costs (col. x col. 12) 13.00 7) x col. 10) 9.00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 0 0 50.00 0 05100 RECOVERY ROOM 51.00 0.000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 0 52.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0.000000 3, 951 54.00 54.00 0 0 54.01 05401 ULTRASOUND 0.000000 3, 405 0 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 55.00 0 05600 RADI OI SOTOPE 0.000000 56 00 0 56 00 0 05700 CT SCAN 57.00 0.000000 26, 086 0 57.00 58.00 05800 MRI 0.000000 3, 772 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 0.000000 0 59.00 0 06000 LABORATORY 0.000000 52, 172 60 00 60 00 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0 62.00 06400 INTRAVENOUS THERAPY 0.000000 0 64.00 0 64.00 06500 RESPIRATORY THERAPY 9, 905 0 65 00 0.000000 0 65 00 0 66.00 06600 PHYSI CAL THERAPY 0.000000 528 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 0 0 67.00 C 06800 SPEECH PATHOLOGY 0 68.00 0.000000 0 68.00 06900 ELECTROCARDI OLOGY 69 00 0.000000 0 69 00 6,606 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 5, 171 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 78, 538 0 73.00 73.00 0 74.00 07400 RENAL DIALYSIS 0.000000 0 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 0 75.00 75.00 03030 ANGI OCARDI OGRAPHY 0 0 76.00 0.000000 0 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 0.000000 89.00 0 0 90.00 09000 CLI NI C 0.000000 0 90.00 0 0 09100 EMERGENCY 0 91.00 0.000000 30, 065 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 4,500 0 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 0.000000 0 94.00 94.00 0 0 09500 AMBULANCE SERVICES 95.00 95.00

0.000000

0.000000

224, 699

0

0

0

0

0

0 96.00

0 97.00

0 200.00

96.00

200.00

09600 DURABLE MEDICAL EQUIP-RENTED

Total (lines 50 through 199)

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

Heal th	Financial Systems	STARKE MEMORI.	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APP0R1	FIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Peri od:	Worksheet D	
					From 01/01/2021	Part V	
				1	To 12/31/2021	Date/Time Pre	pared:
			T' 11	VI V		5/30/2022 10:	09 am_
			ΙΙΤΙ	e XIX	Hospi tal	PPS	
			550 5 1 1	Charges	2 .	Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.			
		1.00	0.00	(see inst.)	(see inst.)		
	ANOLILIA DIVI OFFICIA CONT. OFFITEDO	1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	0.0/5/00		ı			
50.00	05000 OPERATING ROOM	0. 265499	0		0 46, 671	0	
51. 00	05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0. 004852	0		12, 118	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 321210	0		107, 908	0	54.00
54. 01	05401 ULTRASOUND	0. 069656	0		930 49, 930	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0.000000	0		0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 142442	0		9, 844	0	56.00
57.00	05700 CT SCAN	0. 018411	0		255, 253	0	57. 00
58.00	05800 MRI	0. 050655	0		28, 287	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59. 00
60.00	06000 LABORATORY	0. 106918	0		366, 087	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0	0	62. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	0. 882961	0	•	27, 372	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 332865	0		17, 998	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	Ö		0 17,770	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0	•	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 084800	0		48, 794	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0		0 40,774	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	•	0 105	0	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 633098	0			0	72.00
		1	0		2,02.	_	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 156450	0		07,001	0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	0		0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	75. 00
76. 00	03030 ANGI OCARDI OGRAPHY	0. 000000	0		0 0	0	76. 00
00.00	OUTPATIENT SERVICE COST CENTERS			1	_		00.00
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90. 00	09000 CLI NI C	0. 000000	0		0	0	
91. 00	09100 EMERGENCY	0. 196857	0		96, 841	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 990224	0		11, 201	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000			0		94. 00
95.00	09500 AMBULANCE SERVICES	0. 000000	0		O		95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	97. 00
200.00	Subtotal (see instructions)		0		1, 550, 764	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		0		1, 550, 764	0	202. 00

In Lieu of Form CMS-2552-10
Worksheet D
Part V
B1/2021 Date/Time Prepared:
5/30/2022 10:09 am
tal PPS
 Heal th Financial
 Systems
 STARKE
 MEMORIAL
 HOSPITAL

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 Provider
 Provider CCN: 15-0102 Peri od: From 01/01/2021 To 12/31/2021 Title XIX Hospi tal

		0-	-+-	1	
			sts		
	Cost Center Description	Cost	Cost		
		Rei mbursed	Rei mbursed		
		Servi ces	Services Not		
		Subject To	Subject To		
		Ded. & Coins.	Ded. & Coins.		
		(see inst.)	(see inst.)	-	
	1	6. 00	7.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	12, 391		50. 00
51.00	05100 RECOVERY ROOM	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0		52.00
53. 00	05300 ANESTHESI OLOGY		59		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		l .	l e e e e e e e e e e e e e e e e e e e	54.00
			34, 661	l control of the cont	1
54. 01	05401 ULTRASOUND	0	3, 478		54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		55. 00
56.00	05600 RADI 0I SOTOPE	0	1, 402	2	56. 00
57.00	05700 CT SCAN		4, 699		57. 00
58. 00	05800 MRI		1, 433		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0		59. 00
					1
60.00	06000 LABORATORY	0	39, 141		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	•	62. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		64. 00
65.00	06500 RESPI RATORY THERAPY	0	24, 168	3	65. 00
66. 00	06600 PHYSI CAL THERAPY	1 0	5, 991		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		0		67. 00
68. 00	06800 SPEECH PATHOLOGY		o o		68. 00
69. 00	06900 ELECTROCARDI OLOGY		4, 138		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 596		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		10, 926		73. 00
74. 00	07400 RENAL DIALYSIS		0		74. 00
75. 00	07500 ASC (NON-DISTINCT PART)		o o	•	75. 00
76. 00	03030 ANGI OCARDI OGRAPHY		1 0	<u>/ </u>	76. 00
	OUTPATIENT SERVICE COST CENTERS			_	
88. 00	08800 RURAL HEALTH CLINIC				88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89. 00
90.00	09000 CLI NI C	0	0		90.00
91.00	09100 EMERGENCY		97, 807	,	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1		92. 00
72.00			11,071	l	1 72.00
04.00	OTHER REIMBURSABLE COST CENTERS	_			1 04 00
	09400 HOME PROGRAM DIALYSIS		0)	94. 00
95.00	09500 AMBULANCE SERVICES	0)		95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0)	96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD		0		97. 00
200.00			252, 981		200. 00
201.00]		201. 00
201.00	Only Charges		1		201.00
202.00			252 001		202 00
202.00	Net Charges (line 200 - line 201)	0	252, 981	T .	202. 00

Health Financial Systems	STARKE MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0102	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/30/2022 10:09 am
	Title XVIII	Hospi tal	PPS

		Title XVIII	Hospi tal	5/30/2022 10: PPS	09 am
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00 2. 00 3. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bed and observation bed days the next complete this line.	ped and newborn days)	vate room days,	2, 018 2, 018 0	1. 00 2. 00 3. 00
4. 00 5. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room reporting period	31 of the cost	1, 785 0	4. 00 5. 00	
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December :	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)			674	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	tions)		0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nter O on this line)	,	0	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	3	,	0	12.00
13. 00 14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter O on this line	e)	0	13. 00 14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	an (excluding swing-bed to	lays)	0	15. 00 16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	0.00			
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	<u> </u>		0.00	
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	0.00			
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	0. 00			
21. 00	reporting period Total general inpatient routine service cost (see instructions			3, 082, 741	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December \mathbf{x} line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	·		0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		0 3, 082, 741	26. 00 27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges)	line 20)		0. 000000	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 - line 3)	FITTHE 28)		0.00000	31. 00 32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin		=/	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	fferential (line	3, 082, 741	37. 00	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	IOTUENTO.			
00.05	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			4 505 :-	00.00
38. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 527. 62	38.00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		1, 029, 616 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39)	,		1, 029, 616	

Heal th	Financial Systems	STARKE MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10	
	ATION OF INPATIENT OPERATING COST			CN: 15-0102	Peri od:	Worksheet D-1		
					From 01/01/2021 To 12/31/2021			
-			Title	× XVIII	Hospi tal	5/30/2022 10: 0 PPS	09 am_	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost		
		Inpatient Cost Ir	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)		
		1.00	2. 00	3.00	4. 00	5. 00		
42. 00	NURSERY (title V & XIX only)	0	C				42. 00	
	Intensive Care Type Inpatient Hospital Units	1						
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0.0	00	0	43. 00 44. 00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00	
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00	
	Cost Center Description					1.00		
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	Line 200)			1. 00 668, 169	48. 00	
	Total Program inpatient costs (sum of lines			ons)		1, 697, 785	•	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp.	atient routine se	ervices (from	n Wkst. D. sum	of Parts L and	41, 754	50. 00	
			·					
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	16, 820	51. 00	
52. 00	Total Program excludable cost (sum of lines					58, 574	1	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-phy	sician anesth	etist, and	1, 639, 211	53. 00	
	TARGET AMOUNT AND LIMIT COMPUTATION	52)						
54.00						0	54.00	
55.00	Target amount per discharge						55. 00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	not amount (1	ino E4 minus	lino E2)	0		
58. 00	Bonus payment (see instructions)	ing cost and targ	get amount (i	THE 30 IIITIUS	111le 55)		58.00	
59. 00	Lesser of lines 53/54 or 55 from the cost re		59. 00					
	market basket							
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line				the amount by	0.00	60. 00 61. 00	
01.00	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 63. 00	62.00 Relief payment (see instructions)							
03.00	63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	oer 31 of the	e cost reporti	ng period (See	0	64. 00	
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	31 of the c	cost reporting	period (See	0	65. 00	
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costo (lino 6	1 plus lips 4	. E) (+; + o V)/	Lonby) For	0	66. 00	
00.00	CAH (see instructions)	·	•	, ,	3.			
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through [December 31 c	of the cost re	porting period	0	67. 00	
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after Dec	cember 31 of	the cost repo	orting period	o	68. 00	
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line	68)		0	69. 00	
70.00	PART III - SKILLED NURSING FACILITY, OTHER N						70.00	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service o	-					70. 00 71. 00	
72. 00	Program routine service cost (line 9 x line	•	10 70 7 11110				72. 00	
73. 00	Medically necessary private room cost applic						73. 00	
74. 00 75. 00	Total Program general inpatient routine serv	•			ort II column		74. 00 75. 00	
75.00	Capital-related cost allocated to inpatient 26, line 45)	Toutine Service (LOSIS (TIOIII W	MIKSHEEL B, F	art II, Corumii		75.00	
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00	
77. 00	Program capital -related costs (line 9 x line						77. 00	
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovider record	ls)			78. 00 79. 00	
80.00	Total Program routine service costs for comp				us line 79)		80.00	
81.00							81. 00	
82. 00 83. 00	Inpatient routine service cost limitation (I	· · · · · · · · · · · · · · · · · · ·					82. 00 83. 00	
83.00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		,				84.00	
85. 00	Utilization review - physician compensation		s)				85. 00	
86.00	Total Program inpatient operating costs (sum	of lines 83 thro					86. 00	
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					222	87. 00	
88.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		ine 2)			1, 527. 62		
	Observation bed cost (line 87 x line 88) (se	•	•			355, 935		

Health Financial Systems	STARKE MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021	Date/Time Prep 5/30/2022 10:0	pared: 09 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	125, 023	3, 082, 741	0. 04055	6 355, 935	14, 435	90.00
91.00 Nursing Program cost	0	3, 082, 741	0.00000	0 355, 935	0	91.00
92.00 Allied health cost	0	3, 082, 741	0.00000	0 355, 935	0	92.00
93.00 All other Medical Education	0	3, 082, 741	0.00000	0 355, 935	0	93.00

Health Financial Systems	STARKE MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0102	From 01/01/2021	Worksheet D-1 Date/Time Prepared: 5/30/2022 10:09 am
	Title XIX	Hospi tal	PPS

-		Title XIX	Hospi tal	5/30/2022 10:0	09 am
	Cost Center Description	II LIE XIX	110Spi tai	FF3	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days	excluding newborn)		2, 018	1.00
2. 00	Inpatient days (including private room days, excluding swing-k			2, 018	2.00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be		- 21 -6 +1+	1, 785	4.00
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through Decembe	r 31 or the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private roo	om davs) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	, .,		- 1	
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
0.00	reporting period	dava) after December 2	1 of the cost		0 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after becember 3	i or the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	32	9. 00
	newborn days) (see instructions)	3	5		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11 00	through December 31 of the cost reporting period (see instruct		aam daya) aftar	0	11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		dom days) arter	ا	11. 00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
	through December 31 of the cost reporting period	3 .	,		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	ill (excluding swing-bed	uays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	os after December 21 of	the cost	0.00	18. 00
10.00	reporting period	es arter becember 31 or	the cost	0.00	16.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	:)		3, 082, 741	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
24.00	7 x line 19)	or the cost reporting	ng perrod (Trie	ا	24.00
25.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
0, 00	x line 20)				
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ((line 21 minus line 24)		0 3, 082, 741	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	Time 21 minus iine 20)		3, 002, 741	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	- line 28)		0. 000000	31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	tterential (line	3, 082, 741	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 527. 62	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		48, 884	39. 00
40. 00	Medically necessary private room cost applicable to the Progra	•		0	40. 00
	Total Program general inpatient routine service cost (line 39			48, 884	
			·	•	

Heal th	Financial Systems	STARKE MEMORIA	I HOSPITAI		In lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST	STARRE WEWORTA		CN: 15-0102	Peri od:	Worksheet D-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	nared·
						5/30/2022 10:	
	Cost Contor Description	Total	Ti tl Total	e XIX Average Per	Hospi tal	PPS Program Cost	
	Cost Center Description	Inpatient Cost				Program Cost (col. 3 x col.	
				col . 2)		4)	
10.00	NUDGEDY (1) II A A VIV	1.00	2.00	3.00	4. 00	5. 00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0. (00 0		42. 00
43.00	INTENSIVE CARE UNIT	0	С	0. (00 00	0	43. 00
44.00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
						1. 00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		39, 899 88, 783	48. 00 49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine s	ervices (from	n Wkst. D, sun	n of Parts I and	1, 982	50. 00
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	840	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				2, 822	52. 00
53. 00	Total Program inpatient operating cost exclu		ated, non-phy	sician anesth	netist, and	85, 961	
	medical education costs (line 49 minus line	52)					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	Target amount per discharge						55. 00
56.00	Target amount (line 54 x line 55)					0	1
57. 00	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period e	ndina 1006 u	indated and co	omnounded by the	0	58. 00 59. 00
37.00	market basket	portring perrou e	naring 1770, c	apuateu anu co	inpounded by the	0.00	37.00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	1
61. 00	If line 53/54 is less than the lower of line					0	61. 00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		(TITIES 54 X	60), OI 1% OI	the target		
62. 00	Relief payment (see instructions)	,				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	e cost reporti	na period (See	0	64. 00
	instructions)(title XVIII only)					_	
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	r 31 of the d	cost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 6	4 plus line 6	55)(title XVII	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 c	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N				1		70. 00
70.00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service o	-			,		70.00
72. 00	Program routine service cost (line 9 x line			,			72. 00
73. 00	Medically necessary private room cost applic						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital -related cost allocated to inpatient	•			Part II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	,					77. 00
78.00	Inpatient routine service cost (line 74 minu			1->			78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 70)		79. 00 80. 00
81. 00			St IIIII tati Ol	. (11110 /0 11111	143 11110 17)		81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00
83.00	Reasonable inpatient routine service costs ()				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		s)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum						86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	<u> </u>				
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			233 1, 527. 62	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se	•				355, 935	

Health Financial Systems	STARKE MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2021		
				To 12/31/2021	Date/Time Prep 5/30/2022 10:0	pared: Ng am
		Ti tl	e XIX	Hospi tal	PPS	37 diii
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	125, 023	3, 082, 741	0. 04055	6 355, 935	14, 435	90.00
91.00 Nursing Program cost	0	3, 082, 741	0.00000	0 355, 935	0	91.00
92.00 Allied health cost	0	3, 082, 741	0. 00000	0 355, 935	0	92.00
93.00 All other Medical Education	0	3, 082, 741	0.00000	0 355, 935	0	93. 00

INFAII	LIVI ANGILLARI SERVICE COST AFFORTIONMENT	Frovider C	UN. 15-0102	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/30/2022 10:	
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDI ATRI CS			1, 591, 261		30. 00
31.00	03100 I NTENSI VE CARE UNIT			C)	31.00
40.00	04000 SUBPROVI DER - I PF			C		40.00
41. 00 43. 00	O4100 SUBPROVI DER - I RF O4300 NURSERY			0	'	41. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00	05000 OPERATI NG ROOM		0. 2654	99 55, 047	14, 615	50.00
51. 00	05100 RECOVERY ROOM		0.0000	· ·	1	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0.0000		1	1
53. 00	05300 ANESTHESI OLOGY		0. 0048			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 3212			54.00
54.01	05401 ULTRASOUND		0.0696	56 36, 143	2, 518	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C		0.0000	00 0	0	55. 00
56.00	05600 RADI 0I SOTOPE		0. 1424	42 C	0	56. 00
57. 00	05700 CT SCAN		0. 0184			
58. 00	05800 MRI		0. 0506		•	
59. 00	05900 CARDI AC CATHETERI ZATI ON		0.0000		1	59. 00
60.00	06000 LABORATORY		0. 1069	· ·	•	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		0	62.00
64. 00	06400 I NTRAVENOUS THERAPY		0.0000		1	64.00
65. 00	06500 RESPIRATORY THERAPY		0. 8829			
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		0. 3328 0. 0000		1	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY		0.0000			•
69. 00	06900 ELECTROCARDI OLOGY		0.0848			69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY		0.0000		0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.0000			71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 6330			1
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 1564	50 820, 347	128, 343	73. 00
74.00	07400 RENAL DIALYSIS		0.0000	00 0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)		0.0000		•	
76.00	03030 ANGI OCARDI OGRAPHY		0.0000	00 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS		1		1	
88. 00	08800 RURAL HEALTH CLINIC		0.0000		0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	89. 00
90.00	09000 CLINIC		0.0000		1	90.00
91.00	09100 EMERGENCY		0. 1968	· ·	1	91.00
92. 00	O9200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REIMBURSABLE COST CENTERS		0. 9902	24 113, 138	112, 032	92. 00
94. 00	09400 HOME PROGRAM DI ALYSI S		0.0000	00 0	0	94. 00
95.00	09500 AMBULANCE SERVICES		0.0000		1	95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED		0.0000	00	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD		0.0000			•
200.00			0.000	3, 506, 121		1
201.00		(line 61)		C)	201. 00
202.00		•		3, 506, 121		202. 00

Health Financial Systems	STARKE MEMORIAL	HOSPI TAL		In_Lie	u of Form CMS-2	<u> 2552-1</u> 0
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C	CN: 15-0102	Peri od:	Worksheet D-3	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	nared.
				10 12/31/2021	5/30/2022 10:	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description			Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
INDATIONE DOUTING CODYLOG COCT CONTEDC			1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS			1	90, 036		30.00
31. 00 03100 NTENSI VE CARE UNI T				90, 030		31.00
40. 00 04000 SUBPROVI DER - I PF				0		40.00
41. 00 04100 SUBPROVI DER - I RF				0		41.00
43. 00 04300 NURSERY				0		43. 00
ANCILLARY SERVICE COST CENTERS				-		
50.00 05000 OPERATING ROOM			0. 26549	0	0	50.00
51.00 05100 RECOVERY ROOM			0.00000	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM			0.00000	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY			0. 00485	52 0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 32121	0 3, 951	1, 269	54.00
54. 01 05401 ULTRASOUND			0.06965	3, 405	237	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C			0.00000	00	0	55. 00
56. 00 05600 RADI 0I SOTOPE			0. 14244		0	56. 00
57.00 05700 CT SCAN			0. 01841		480	57. 00
58. 00 05800 MRI			0. 05065		191	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON			0.00000		0	59. 00
60. 00 06000 LABORATORY			0. 10691		5, 578	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL			0.00000		0	62.00
64. 00 06400 I NTRAVENOUS THERAPY			0.00000		0	64.00
65. 00 06500 RESPI RATORY THERAPY			0. 88296		8, 746	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 33286		176	
67. 00 06700 OCCUPATI ONAL THERAPY			0.00000		0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY			0. 00000 0. 08480		0 560	68. 00 69. 00
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY			0.00000		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0.00000		0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 63309		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS			0. 05507			73.00
74. 00 07400 RENAL DIALYSIS			0. 00000		0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)			0. 00000			75. 00
76. 00 03030 ANGI OCARDI OGRAPHY			0. 00000			76. 00
OUTPATIENT SERVICE COST CENTERS				-		
88. 00 08800 RURAL HEALTH CLINIC			0.00000	00 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER			0.00000	0 0	0	89. 00
90. 00 09000 CLI NI C			0.00000	0 0	0	90.00
91. 00 09100 EMERGENCY			0. 19685	30, 065	5, 919	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART			0. 99022	4, 500	4, 456	92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS			0.00000	0 0	0	
95. 00 09500 AMBULANCE SERVICES						95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED			0. 00000		0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD			0. 00000		0	97. 00
200.00 Total (sum of lines 50 through 94 and 96				224, 699	39, 899	
201.00 Less PBP Clinic Laboratory Services-Prog	gram only charges	(IIne 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)			I	224, 699	I	202. 00

Health Financial Systems	STARKE MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0102	Peri od:	Worksheet D-3
	0 1 00N 45 1400	From 01/01/2021	

INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider Co	CN: 15-0102	Peri od:	Worksheet D-3	
		Component (CCN: 15-U102	From 01/01/2021 To 12/31/2021	Date/Time Pre	
-		Ti +I	e XIX	Swing Beds - SNF	5/30/2022 10: PPS	09 alli
	Cost Center Description	11 (1	Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
			3	Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		ı			
	03000 ADULTS & PEDI ATRI CS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
	04000 SUBPROVI DER - I PF					40. 00 41. 00
	O4100 SUBPROVI DER - RF O4300 NURSERY					43.00
43.00	ANCI LLARY SERVI CE COST CENTERS					43.00
50.00	05000 OPERATING ROOM		0. 26549	19 0	0	50.00
	05100 RECOVERY ROOM		0.00000		0	
	05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	
	05300 ANESTHESI OLOGY		0. 00485		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 32121	0 0	0	54. 00
54.01	05401 ULTRASOUND		0. 06965	66 0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 00000	00	0	55. 00
	05600 RADI 0I SOTOPE		0. 14244	2 0	0	56. 00
	05700 CT SCAN		0. 01841		0	
	05800 MRI		0. 05065		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 00000		0	59. 00
60.00	06000 LABORATORY		0. 10691		0	60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 00000		0	62. 00
64.00	06400 I NTRAVENOUS THERAPY		0.00000		0	64.00
65. 00	06500 RESPI RATORY THERAPY		0. 88296		0	65. 00
66. 00	06600 PHYSI CAL THERAPY		0. 33286		0	66.00
	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY		0. 00000 0. 00000		0	67. 00 68. 00
	06900 ELECTROCARDI OLOGY		0. 08480		0	69.00
	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY		0. 00000		0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 00000		0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 63309		Ö	
	07300 DRUGS CHARGED TO PATIENTS		0. 15645		0	73. 00
	07400 RENAL DIALYSIS		0.00000		0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)		0.00000	00	0	75. 00
76.00	03030 ANGI OCARDI OGRAPHY		0.00000	0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC		0. 00000		0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	
	09000 CLI NI C		0.00000		0	
	09100 EMERGENCY		0. 19685		0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 99022	24 0	0	92.00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S		0.00000	00 0	0	94. 00
	09500 AMBULANCE SERVICES		0.00000	0	U	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED		0. 00000	00 0	0	1
	09700 DURABLE MEDI CAL EQUI P-SOLD		0. 00000		0	
200.00			3. 23000	0		200.00
201.00		(line 61)		0		201. 00
202.00				0		202. 00
			•	•		•

Health Financial Systems	STARKE MEMORIAL HOSPITAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider C	CCN: 15-0102		Worksheet E Part A Date/Time Prepared: 5/30/2022 10:09 am

			10 12/31/2021	5/30/2022 10:0	
		Title XVIII	Hospi tal	PPS	
	DADT A LABOUT HOODITH OFFILIATE LIBER LIBER			1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (s	see	0 893, 591	1. 00 1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurri	ng on or after October	I (see	438, 441	1. 02
1. 03	Instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October				1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring (on or after	0	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)				2. 00
2. 01	Outlier reconciliation amount			0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructi	•		0	2. 02
2. 03	Outlier payments for discharges occurring prior to October 1			0	2. 03
2.04	Outlier payments for discharges occurring on or after October	1 (see instructions)		720 210	2. 04
3. 00 4. 00	Managed Care Simulated Payments	sting poriod (see instru	ations)	720, 210	3. 00 4. 00
4.00	Bed days available divided by number of days in the cost report Indirect Medical Education Adjustment	tring perrou (see riistru	trons)	14. 36	4.00
5. 00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)	t recent cost reporting p	period ending on	0. 00	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e)	ne criteria for an add-on	n to the cap for	0. 00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified α ACA \S 5503 reduction amount to the IME cap as specified under			0. 00 0. 00	7. 00 7. 01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa			0. 00	8. 00
0.00	affiliated programs in accordance with 42 CFR 413.75(b), 413.1998), and 67 FR 50069 (August 1, 2002).			0.00	0.00
8. 01	The amount of increase if the hospital was awarded FTE cap sloreport straddles July 1, 2011, see instructions.	ots under § 5503 of the A	ACA. If the cost	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap sto under § 5506 of ACA. (see instructions)	ots from a closed teachi	ng hospital	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line instructions)	es (8, 8,01 and 8,02) (9	see	0.00	9. 00
10. 00	FTE count for allopathic and osteopathic programs in the curre	ent year from your record	ds	0.00	10. 00
11. 00	FTE count for residents in dental and podiatric programs.				11. 00
12. 00	Current year allowable FTE (see instructions)			0. 00	
13. 00	Total allowable FTE count for the prior year.			0. 00	
14. 00	Total allowable FTE count for the penultimate year if that year	ar ended on or after Sep	tember 30, 1997,	0. 00	14. 00
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16. 00	Adjustment for residents in initial years of the program			0.00	
	Adjustment for residents displaced by program or hospital clos	sure			17. 00
	Adjusted rolling average FTE count			0.00	1
19.00	Current year resident to bed ratio (line 18 divided by line 4)).		0.000000	19. 00
	Prior year resident to bed ratio (see instructions)			0. 000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422	of the MMA		0	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE reside		R 412. 105	0.00	23. 00
24. 00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0. 00	24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the I	ower of line 23 or line	24 (see	0. 00	1
26. 00	instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	
28. 00	IME add-on adjustment amount (see instructions)			0.000000	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions))		0	28. 01
29.00	Total IME payment (sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0) Disproportionate Share Adjustment	1)		0	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	4. 36	30.00
31. 00	Percentage of Medicaid patient days (see instructions)	2.1. 2.2.7.2 (000 1.1.011 40		14. 09	
32. 00	Sum of lines 30 and 31			18. 45	1
	Allowable disproportionate share percentage (see instructions))			33. 00
34. 00	Disproportionate share adjustment (see instructions)			15, 785	34. 00

CALCUL	Financial Systems STARKE MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0102	Peri od:	wu of Form CMS-2 Worksheet E	
			From 01/01/2021 To 12/31/2021	Date/Time Pre	
		Title XVIII	Hospi tal	5/30/2022 10: 0 PPS	09 am
		THE AVIII		On/After 10/1	
			1. 00	2. 00	
	Uncompensated Care Adjustment				
5.00	Total uncompensated care amount (see instructions)		0 00000000		
5. 01 5. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, enter	r zoro on this lino) (so	0. 000000000 e 285, 618		
5. 02	instructions)	zero on this rine) (se	200,010	137, 137	35.0
5. 03	Pro rata share of the hospital uncompensated care payment amou	unt (see instructions)	213, 627	35, 076	35. 0
6. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.03		248, 703		36.0
	Additional payment for high percentage of ESRD beneficiary dis	scharges (lines 40 throug			
0.00	Total Medicare discharges (see instructions)		0		40.0
1.00	Total ESRD Medicare discharges (see instructions)	i ono)	0		41.0
1. 01	Total ESRD Medicare covered and paid discharges (see instructi Divide line 41 by line 40 (if less than 10%, you do not qualif		0.00	1	41. 0 42. 0
3. 00	Total Medicare ESRD inpatient days (see instructions)	ry ron adjustment)	0.00		43.0
4. 00	Ratio of average length of stay to one week (line 43 divided b	by line 41 divided by 7	0. 000000		44. 0
	days)				
5. 00	Average weekly cost for dialysis treatments (see instructions)		0.00		45. 0
6. 00	Total additional payment (line 45 times line 44 times line 41.	. 01)	0		46. 0
7. 00	Subtotal (see instructions)		1, 596, 520		47.0
8. 00	Hospital specific payments (to be completed by SCH and MDH, sm only. (see instructions)	maii rurai nospitais	1, 257, 856		48. 0
	on y. (see Thati detions)			Amount	
				1. 00	
9. 00	Total payment for inpatient operating costs (see instructions)			1, 596, 520	49. 0
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			98, 601	
1.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.0
3. 00	Direct graduate medical education payment (from Wkst. E-4, lin	ne 49 see instructions).		0	
4. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			16, 629	1
4. 01	Islet isolation add-on payment			0	1
5. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69	9)		0	1
6. 00	Cost of physicians' services in a teaching hospital (see intru			0	56.0
7. 00	Routine service other pass through costs (from Wkst. D, Pt. II		nrough 35).	0	57.0
8. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 11 line 200)		0	
9.00	Total (sum of amounts on lines 49 through 58)			1, 711, 750 0	1
0.00	Primary payer payments Total amount payable for program beneficiaries (line 59 minus	line 60)		1, 711, 750	1
2. 00	Deductibles billed to program beneficiaries	1111c 00)		219, 404	
3. 00	Coinsurance billed to program beneficiaries			0	l
4. 00	Allowable bad debts (see instructions)			24, 223	64. (
5. 00	Adjusted reimbursable bad debts (see instructions)			15, 745	
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		3, 402	
	Subtotal (line 61 plus line 65 minus lines 62 and 63)	!: +- MC DDC- (-	!+	1, 508, 091	
8. 00 9. 00	Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	1
9. 00 0. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(FOI SCH SEE FIISTI UCTIONS	5)	0	1
0. 50	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) adiustment (see	nstructions)	0	1
	Demonstration payment adjustment amount before sequestration	. , ,		Ö	
	SCH or MDH volume decrease adjustment (contractor use only)			0	
0. 87	Pioneer ACO demonstration payment adjustment amount (see instr	ructions)			70. 8
0. 87 0. 88 0. 89				0	1
0. 87 0. 88 0. 89 0. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 9
0. 87 0. 88 0. 89 0. 90 0. 91	HSP bonus payment HRR adjustment amount (see instructions)				1
70. 87 70. 88 70. 89 70. 90 70. 91 70. 92	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70. 9
70. 87 70. 88 70. 89 70. 90 70. 91	HSP bonus payment HRR adjustment amount (see instructions)				70. 9 70. 9

				To 12/31/2021		pared:
		Ti tl o	XVIII	Hospi tal	5/30/2022 10: PPS	09 am_
		11 11 6		(yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	column 0	2	2021	291, 165	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in		2	2022	132, 616	70. 97
70. 98	the corresponding federal year for the period ending on or aft Low Volume Payment-3	er 10/1)			0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	9 & 70)			1, 931, 600	71.00
71. 01	Sequestration adjustment (see instructions)				0	71. 01
71. 02	Demonstration payment adjustment amount after sequestration				0	
	Sequestration adjustment-PARHM pass-throughs Interim payments				1, 880, 949	71. 03
	Interim payments-PARHM				1,000,717	72. 01
73.00	Tentative settlement (for contractor use only)				0	73. 00
73. 01	Tentative settlement-PARHM (for contractor use only)					73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02 73)	2, 72, and			50, 651	74. 00
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordan CMS Pub. 15-2, chapter 1, §115.2	nce with			288, 862	75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum o	of 2.03			0	90. 00
01 00	plus 2.04 (see instructions)				0	91.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2 Operating outlier reconciliation adjustment amount (see instru	ıcti ons)			0	1
	Capital outlier reconciliation adjustment amount (see instruct	,			0	
	The rate used to calculate the time value of money (see instru				0.00	1
95. 00	Time value of money for operating expenses (see instructions)				0	
96. 00	Time value of money for capital related expenses (see instruct	i ons)		D : 1 10/1	0 (4.6) 40 (4	96. 00
				Prior to 10/1 1.00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment					1
	HVBP adjustment factor (see instructions)			0.0000000000	1.0000000000	1
102.00	HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment	5)		0	0	102. 00
103.00	HRR adjustment factor (see instructions)			0. 9997	1. 0000	103. 00
	HRR adjustment amount for HSP bonus payment (see instructions)			0		104. 00
	Rural Community Hospital Demonstration Project (§410A Demonstr					
200.00	Is this the first year of the current 5-year demonstration per	iod under t	he 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement					+
201 00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	49)				201. 00
	Medicare discharges (see instructions)	,				202. 00
	Case-mix adjustment factor (see instructions)					203. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year (of the curren	t 5-year demonst	rati on	
204.00	period) Medicare target amount					204 00
	Redicare target amount Case-mix adjusted target amount (line 203 times line 204)					204. 00 205. 00
	Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement					
	Program reimbursement under the §410A Demonstration (see instr	,				207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	line 59)				208. 00
	Adjustment to Medicare IPPS payments (see instructions)					209. 00
	Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)					210. 00 211. 00
Z 1 1. UC	Comparision of PPS versus Cost Reimbursement					1211.00
212.00	Total adjustment to Medicare Part A IPPS payments (from line 2	211)				212. 00
213.00	Low-volume adjustment (see instructions)					213. 00
210 00						
∠18. UU	Net Medicare Part A IPPS adjustment (difference between PPS an (line 212 minus line 213) (see instructions)	nd cost reim	bursement)			218. 00

| Period: | Worksheet E | From 01/01/2021 | Part A Exhibit 4 | Date/Time Prepared: | 5/30/2022 | 10: 09 am Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0102

						0 12/31/2021	5/30/2022 10:0	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
1.00	DRG amounts other than outlier	0 1. 00	1. 00	2. 00	3.00	4. 00	5. 00 0	1. 00
1.00	payments	1.00	U	U		U	U	1.00
1. 01	DRG amounts other than outlier	1. 01	893, 591	0	893, 591		893, 591	1. 01
4 00	payments for discharges occurring prior to October 1					400 444	400 444	4 00
1. 02	DRG amounts other than outlier payments for discharges	1. 02	438, 441	0		438, 441	438, 441	1. 02
	occurring on or after October							
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		O	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to	2. 03	0	0	0		0	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2. 04	0	0		О	0	2. 03
3. 00	instructions) Operating outlier	2. 01	0	0	0	0	0	3. 00
4. 00	reconciliation Managed care simulated	3. 00	720, 210	0	454, 165	266, 045		4. 00
	payments				·	·	·	
	Indirect Medical Education Adju	ustment						
5.00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
6. 01	instructions) IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
	managed care (see instructions)							
7 00	Indirect Medical Education Adju					0.000000		7 00
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8.00	IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see	28. 01	0	0	0	0	0	8. 01
9. 00	instructions) Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
9. 01	lines 6 and 8) Total IME payment for managed	29. 01	0	0	0	0	0	9. 01
	care (sum of lines 6.01 and 8.01)							
	Disproportionate Share Adjustme							
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 0474	0. 0474	0. 0474	0. 0474		10. 00
11. 00	instructions) Disproportionate share	34.00	15, 785	0	10, 589	5, 196	15, 785	11. 00
11. 01	adjustment (see instructions) Uncompensated care payments	36.00	248, 703	0	186, 527	62, 176	248, 703	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	centage of ESR 46.00	RD beneficiary o	di scharges 0	0	0	0	12. 00
12.00	(see instructions)	47.00	1 50/ 500	^	1 000 707	FOF 040	1 50/ 500	12 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	47. 00 48. 00	1, 596, 520 0	0	1, 090, 707 0	505, 813 0	1, 596, 520 0	13. 00 14. 00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	1, 596, 520	0	1, 090, 707	505, 813	1, 596, 520	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	98, 601	0	73, 951	24, 650	98, 601	16. 00

	ALCOME CAEGOLATION EXITED TO			Trovider e	!	From 01/01/2021 Fo 12/31/2021	5/30/2022 10:	pared:
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2. 00	3. 00	4. 00	5. 00	
	Special add-on payments for new technologies	54.00	16, 629	16, 629	'	0	16, 629	17. 00
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	1	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see		0	0	1	0	0	18. 00
19. 00	instructions) SUBTOTAL			16, 629	1, 164, 65	530, 463	1, 711, 750	19. 00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	98, 601	0	73, 95	1 24, 650	98, 601	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	o	0		0	0	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0.0000	0.000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.000	0. 0000		24. 00
25. 00	1	11.00	0	0		0	0	25. 00
26. 00	1 '	12. 00	98, 601	0	73, 95	1 24, 650	98, 601	26. 00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2. 00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 25000			27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			291, 16	5	291, 165	28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 97				132, 616	132, 616	29. 00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

-		Title XVIII	Hospi tal	5/30/2022 10: PPS	09 am_
		THE CONTRACTOR	110061 (41		
	DADT D. HEDLOAL AND OTHER HEALTH CERVILORS			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			1, 842	1.00
2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)			2, 057, 313	2.00
3.00	OPPS payments			1, 532, 153	3. 00
4.00	Outlier payment (see instructions)			2, 370	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions))		0.000	5.00
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0.00	6. 00 7. 00
8. 00	Transitional corridor payment (see instructions)			0.00	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col	. 13, line 200		0	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			1, 842	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			11, 774	12 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69))		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			11, 774	1
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for payment			0	15.00
16. 00	Amounts that would have been realized from patients liable for payment had such payment been made in accordance with 42 CFR §413.13(e)	ent for services or	n a chargebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			11, 774	1
19. 00	Excess of customary charges over reasonable cost (complete only if I	ine 18 exceeds lir	ne 11) (see	9, 932	1
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete only if I	ine 11 exceeds lir	ne 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)			1, 842	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instruction	ıs)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			1, 534, 523	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			163	1 25 00
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (f	For CAH see instru	ıctions)	278, 750	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus th			1, 257, 452	
	instructions)		- `		
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50))		0	28. 00
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 1, 257, 452	29. 00 30. 00
31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			309	
32. 00	Subtotal (line 30 minus line 31)			1, 257, 143	ı
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34. 00 35. 00	Allowable bad debts (see instructions)			76, 880 49, 972	
36. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instruction	15)		28, 193	
37. 00	Subtotal (see instructions)	,		1, 307, 115	1
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced dev	vicas (saa instruc	i one)	0	39. 97 39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	n ces (see mistruci	.1 0113)	0	39. 99
40. 00	Subtotal (see instructions)			1, 307, 115	
40. 01	Sequestration adjustment (see instructions)			0	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs			1 257 /5/	40. 03
41. 00 41. 01	Interim payments Interim payments-PARHM			1, 257, 656	41. 00 41. 01
42. 00	Tentative settlement (for contractors use only)			0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			49, 459	
43. 01	Balance due provider/program-PARHM (see instructions)			_	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance wit	in CMS Pub. 15-2, c	chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	
93.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93. 00 94. 00
/ 4 . 00	TOTAL (Sum OF TITIES /T WING 73)			0	1 /4.00

Health Financial Systems STA ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: Provi der CCN: 15-0102

				10 12/31/2021	5/30/2022 10:0	
		Ti tl e	xVIII	Hospi tal	PPS	
		Inpatier	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4. 00	
1.00	Total interim payments paid to provider		1, 880, 94	9	1, 257, 656	1. 00
2.00	Interim payments payable on individual bills, either			0	o	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		1	_1	_	
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02			1	0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3. 05				0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		1	ol	0	3. 50
3. 51	ADJUSTNIENTS TO PROGRAM		1	0		3. 50
3. 52				0		3. 51
3. 53				0		3. 53
3. 54				Ö	l ől	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	٥	3. 99
0. 77	3. 50-3. 98)				Ĭ	0. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 880, 94	9	1, 257, 656	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 04	Program to Provider		1			F 04
5. 01	TENTATI VE TO PROVI DER		1	0	0	5. 01 5. 02
5. 02 5. 03				0	0	5. 02
5.03	Provider to Program			u _l	U	5. 03
5. 50	TENTATI VE TO PROGRAM		I	o	0	5. 50
5. 51	TENTATI VE TO TROOKAWI		1	Ö	l ől	5. 51
5. 52			1	Ö	Ö	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		50, 65	1	49, 459	6. 01
6.02	SETTLEMENT TO PROGRAM			0	0	6. 02
7.00	Total Medicare program liability (see instructions)		1, 931, 60		1, 307, 115	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00			0	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Health Financial Systems STARKE MEMORIAL HOSPITAL In Lieu of Form CMS-2552 CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0102 Period: Worksheet E-1 From 01/01/2021 Part II	
To 12/31/2021 Date/Ti me Prepare 5/30/2022 10:09 a	
Title XVIII Hospital PPS	
1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	00
	. 00
	. 00
reporting periods beginning on or after 10/01/2013, line 32) 3.00 Medicare HMO days from Wkst. S-3. Pt. L. col. 6. line 2	. 00
	. 00
reporting periods beginning on or after 10/01/2013, line 32)	. 00
	. 00
	. 00
	. 00
Line 168	00
	. 00
	. 00
	. 00
I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH	
	. 00
	. 00
	. 00

Component CCN: 15-U102 To 12/31/2021 Date/Time Prepared: 5/30/2022 10:09 am Title XIX Swing Beds - SNF PPS Part A Part B 1.00 2.00 COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions) 0 1.00 0 Inpatient routine services - swing bed-NF (see instructions) 2.00 2.00 Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, 0 3.00 3.00 Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions) Nursing and allied health payment-PARHM (see instructions) 3.01 3.01 4.00 Per diem cost for interns and residents not in approved teaching program (see 0.00 4.00 instructions) 5. 00 Program days 5.00 6.00 Interns and residents not in approved teaching program (see instructions) 0 6.00 7.00 Utilization review - physician compensation - SNF optional method only 0 0 0 7.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 8 00 8 00 Primary payer payments (see instructions) 9.00 9.00 10.00 Subtotal (line 8 minus line 9) 10.00 0 11.00 Deductibles billed to program patients (exclude amounts applicable to physician 11.00 professional services) 0 12 00 Subtotal (line 10 minus line 11) 12 00 Coinsurance billed to program patients (from provider records) (exclude coinsurance 0 13.00 13.00 for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 0 14.00 15.00 Subtotal (see instructions) 0 15.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.00 16.00 16.50 Pioneer ACO demonstration payment adjustment (see instructions) 16.50 Rural community hospital demonstration project (§410A Demonstration) payment 16.55 16.55 adjustment (see instructions) 16. 99 ${\tt Demonstration}\ \ {\tt payment}\ \ {\tt adjustment}\ \ {\tt amount}\ \ {\tt before}\ \ {\tt sequestration}$ 16.99 0 17.00 Allowable bad debts (see instructions) 0 0 0 0 0 17.00 Adjusted reimbursable bad debts (see instructions) 17.01 17.01 18.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 18.00 19.00 Total (see instructions) 19 00 19. 01 Sequestration adjustment (see instructions) 19.01 19.02 Demonstration payment adjustment amount after sequestration) 19.02 Sequestration adjustment-PARHM pass-throughs 19.03 19.03 19. 25 Sequestration for non-claims based amounts (see instructions) 0 19. 25 20.00 Interim payments 20.00 20.01 Interim payments-PARHM 20.01 21.00 Tentative settlement (for contractor use only) 21 00 Tentative settlement-PARHM (for contractor use only) 21.01 22. 00 Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 22.00 Balance due provider/program-PARHM (see instructions) 22.01 22.01 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 23.00 chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 200.00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. 200.00 Cost Reimbursement 201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 201.00 66 (title XVIII hospital)) 202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 202.00 200 (title XVIII swing-bed SNF)) 203.00 Total (sum of lines 201 and 202) 203 00 204.00 Medicare swing-bed SNF discharges (see instructions) 204.00 Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration peri od) 205.00 Medicare swing-bed SNF target amount 205. 00 206.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) 206.00 Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) 207.00 208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 208. 00 and 3) 209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 209.00 210.00 Reserved for future use 210.00 Comparision of PPS versus Cost Reimbursement 215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00

instructions)

Health Financial Systems	STARKE MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0102	Peri od: Worksheet E-3 From 01/01/2021 Part VII To 12/31/2021 Date/Time Prepared:

		=	To 12/31/2021	Date/Time Pre 5/30/2022 10:	
		Title XIX	Hospi tal	PPS	<u> </u>
			Inpatient	Outpati ent	
			1, 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			252, 981	2.00
3.00	Organ acquisition (certified transplant centers only)		0	, , ,	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	252, 981	4. 00
5.00	Inpatient primary payer payments		0	,	5. 00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	252, 981	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		90, 036		8. 00
9.00	Ancillary service charges		224, 699	1, 550, 764	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		314, 735	1, 550, 764	12. 00
	CUSTOMARY CHARGES		_		
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis			_	
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
15 00	a charge basis had such payment been made in accordance with 4	12 CFR §413.13(e)	0.000000	0.000000	15 00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
16. 00 17. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete onl	vifling 14 avecade	314, 735	1, 550, 764	1
17.00	line 4) (see instructions)	y IT TITLE TO exceeds	314, 735	1, 297, 783	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	vifline 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	y IT TITLE 4 EXCECUS TITLE		O	10.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		0	252, 981	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		ers.		
22. 00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	26. 00
	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	252, 981	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	252, 981	1
32. 00	Deducti bl es		0	0	
33. 00	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	34.00
35. 00			0	252 001	35. 00
36. 00 37. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and REMOVE SETTLEMENT	1 33)	0	252, 981 -252, 981	1
			0	-252, 981 0	•
39. 00	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst F-4)		0	0	39.00
40. 00	, , , , , , , , , , , , , , , , , , , ,		0	0	
41. 00	Total amount payable to the provider (sum of lines 38 and 39) Interim payments		0	0	
41.00	Balance due provider/program (line 40 minus line 41)		0	0	
43. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2	0	0	43. 00
10.00	chapter 1, §115.2				10.00
	1 P		1	ı	'

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

Provider CCN: 15-0102

Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/30/2022 10:09 am

Speci fi c Endowment Fund General Fund Plant Fund Purpose Fund 1.00 3.00 4.00 2.00 CURRENT ASSETS 1, 295 1.00 Cash on hand in banks 0 0 0 1.00 0 0 2.00 Temporary investments 0 2.00 0 3.00 Notes receivable 0 0 3.00 0 4 00 4, 537, 409 4 00 Accounts receivable 0 0 5.00 Other receivable 0 0 5.00 -1, 700, 878 6.00 Allowances for uncollectible notes and accounts receivable 6.00 0 7.00 Inventory 333, 781 0 0 7.00 0 8.00 Prepaid expenses 399, 956 0 8.00 1, 032 0 9.00 Other current assets 0 9.00 10 00 Due from other funds 0 0 0 10 00 3, 572, 595 Total current assets (sum of lines 1-10) 0 0 11.00 0 11 00 FIXED ASSETS 12.00 Land 0 0 0 12.00 Land improvements 100, 715 0 13.00 0 0 0 0 0 0 0 0 0 0 0 0 0 13.00 οl 14.00 Accumulated depreciation -12.4270 14.00 15.00 Bui I di ngs 0 0 15.00 0 16.00 Accumulated depreciation 16.00 1, 409, 783 0 17.00 Leasehold improvements 17.00 0 0 18 00 Accumulated depreciation -758, 450 0 18 00 Fi xed equipment 39, 983 19.00 19.00 0 20.00 Accumulated depreciation -31, 031 0 20.00 0 21.00 Automobiles and trucks 3, 610 0 21.00 22.00 Accumulated depreciation -3, 610 0 22.00 23.00 Major movable equipment 3, 537, 546 0 0 23.00 Accumulated depreciation -2, 623, 988 0 24.00 0 24.00 0 25.00 Mi nor equi pment depreci able 804, 480 Λ 25, 00 26.00 Accumulated depreciation -625, 166 0 0 26.00 27.00 HIT designated Assets 0 0 0 0 27.00 0 28.00 Accumulated depreciation Ω 0 28.00 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 30.00 Total fixed assets (sum of lines 12-29) 1,841,445 0 30.00 OTHER ASSETS 31 00 Investments O 0 0 31 00 0 0 32.00 Deposits on Leases C 0 32.00 Due from owners/officers 0 0 0 33.00 33.00 0 34.00 Other assets 662, 508 0 0 34.00 0 Total other assets (sum of lines 31-34) 35.00 662, 508 0 35, 00 6, 076, 548 36.00 Total assets (sum of lines 11, 30, and 35) 0 0 0 36.00 CURRENT LIABILITIES 37 00 521 995 O 0 n 37 00 Accounts payable 0 0 38.00 Salaries, wages, and fees payable 684, 393 0 38.00 0 Payroll taxes payable -250 0 0 39.00 39.00 0 40.00 Notes and Loans payable (short term) 0 40.00 155, 267 0 0 Deferred income 41 00 41 00 0 42.00 Accelerated payments 42.00 43.00 Due to other funds -10, 375, 713 0 0 0 43.00 Other current liabilities 0 0 44.00 136, 344 0 44.00 Total current liabilities (sum of lines 37 thru 44) 0 -8, 877, 964 0 45.00 0 45.00 ONG TERM LIABILITIES 46.00 Mortgage payable 0 46.00 0 0 47.00 Notes payable 0 0 47.00 48 00 Unsecured Loans 0 0 0 48 00 Other long term liabilities 369, 889 0 0 49.00 49.00 0 50 00 Total long term liabilities (sum of lines 46 thru 49) 369, 889 0 0 0 50.00 Total liabilities (sum of lines 45 and 50) 51.00 -8, 508, 075 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 14, 584, 623 52.00 53.00 Specific purpose fund 0 53.00 Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted 54.00 0 54.00 55.00 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 57.00 0 58.00 0 58.00 replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 14, 584, 623 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 6,076,548 0 0 0 60.00

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					10 12/31/2021	5/30/2022 10:0	
		General	Fund	Special P	urpose Fund	Endowment Fund	
					T		
		1.00	2. 00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		8, 904, 082		C		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5, 680, 539				2.00
3.00	Total (sum of line 1 and line 2)		14, 584, 621		C)	3.00
4.00	ROUNDING	2			0	0	4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8. 00 9. 00						0	8. 00 9. 00
10.00	Total additions (sum of line 4-9)		2		٦	-	10. 00
11. 00	Subtotal (line 3 plus line 10)		14, 584, 623				11. 00
12. 00	Deductions (debit adjustments) (specify)	0	14, 504, 625	1	o	Ö	12. 00
13. 00	Seader one (depril adjustments) (speeting)				o	0	13. 00
14.00		0			0	0	14.00
15.00		0			0	0	15.00
16. 00		0			0	0	16.00
17. 00		0			0	0	17. 00
18. 00	Total deductions (sum of lines 12-17)		0		C		18. 00
19. 00	Fund balance at end of period per balance		14, 584, 623		C)	19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3. 00 4. 00	Total (sum of line 1 and line 2) ROUNDING	O O	0		0		3. 00 4. 00
5. 00	ROUNDING		0				4. 00 5. 00
6. 00			0				6. 00
7. 00			0				7. 00
8.00			0				8. 00
9.00			0				9. 00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11. 00	Subtotal (line 3 plus line 10)	0			0		11.00
12. 00	Deductions (debit adjustments) (specify)		0				12. 00
13.00			0				13.00
14. 00 15. 00			0				14. 00 15. 00
16. 00			0				16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0			0		18. 00
19. 00	Fund balance at end of period per balance				О		19. 00
	sheet (line 11 minus line 18)						

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0102

			To	12/31/2021	Date/Time Prep 5/30/2022 10:0	
	Cost Center Description		Inpati ent	Outpati ent	Total	J7 dili
	COST CONTON DOSCITATION		1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES		1.00	2.00	3. 00	
	General Inpatient Routine Services					
1.00	Hospi tal		4, 648, 925		4, 648, 925	1. 00
2.00	SUBPROVI DER - I PF		0, 040, 723		0, 040, 729	2. 00
3.00	SUBPROVIDER - IRF		0		0	3. 00
4. 00	SUBPROVI DER		U		U	4. 00
5.00	Swing bed - SNF		0		0	5. 00
6. 00	Swing bed - NF		0		0	6. 00
7. 00	SKILLED NURSING FACILITY		U		U	7. 00
8.00	NURSI NG FACILITY					8. 00
9. 00	OTHER LONG TERM CARE					9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)		4, 648, 925		4, 648, 925	
10.00	Intensive Care Type Inpatient Hospital Services		4, 040, 723		4, 040, 723	10.00
11. 00	INTENSIVE CARE UNIT		O		0	11. 00
12. 00	CORONARY CARE UNIT		O		O	12.00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lir	105	0		0	
10.00	11-15)	ies	U		U	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		4, 648, 925		4, 648, 925	17. 00
18. 00	Ancillary services		7, 815, 271	51, 426, 881	59, 242, 152	18. 00
19. 00	Outpatient services		1, 773, 964	13, 470, 938	15, 244, 902	19. 00
20. 00	RURAL HEALTH CLINIC		1, 773, 704	13, 470, 730	13, 244, 702	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	o	0	21. 00
22. 00	HOME HEALTH AGENCY		U	0	0	22. 00
23. 00	AMBULANCE SERVICES		0	0	0	23. 00
24. 00	CMHC	•	U	0	0	24. 00
24. 00	CORF		0	0	0	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)		0	0	0	25. 00
26. 00	HOSPI CE		0	0	0	26. 00
27. 00	OTHER (SPECIFY)		0	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wket	14, 238, 160	64, 897, 819	79, 135, 979	
20.00	G-3, line 1)	WKSL.	14, 236, 100	04, 077, 017	17, 133, 717	20.00
	PART II - OPERATING EXPENSES	<u> </u>				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			13, 565, 722		29. 00
30. 00	ADD (SPECIFY)		О	13, 303, 722		30. 00
31. 00	(SI EGITT)		0			31. 00
32. 00			Ö			32. 00
33. 00			0			33. 00
34. 00			0			34. 00
35. 00			0			35. 00
36. 00	Total additions (sum of lines 30-35)		J	0		36. 00
37. 00	DEDUCT (SPECIFY)		0	Ĭ		37. 00
38. 00	DEBOOT (SEESTED)		0			38. 00
39. 00			0			39. 00
40. 00			Ö			40. 00
41.00			0			41. 00
42.00	Total deductions (sum of lines 37-41)		U	٥		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(t	ransfer		13, 565, 722		43. 00
45. 00	to Wkst. G-3, line 4)	.1 4.131 61		13, 303, 722		13.00
	1 9/ // //	1	l	ı		

	Financial Systems	STARKE MEMORIAL			u of Form CMS-2	
SIAIEN	ENT OF REVENUES AND EXPENSES		Provider CCN: 15-0102	Peri od: From 01/01/2021	Worksheet G-3	
				To 12/31/2021	Date/Time Pre	pared:
					5/30/2022 10:0	
	I=				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Par				79, 135, 979	1.0
2. 00	Less contractual allowances and discounts of	on patients' account	S		61, 075, 041	2. 00
3.00	Net patient revenues (line 1 minus line 2)		0)		18, 060, 938	3. 0
4. 00	Less total operating expenses (from Wkst. (3)		13, 565, 722	
5. 00	Net income from service to patients (line 3	3 minus line 4)			4, 495, 216	5.00
5. 00	OTHER INCOME Contributions, donations, bequests, etc			1	0	6.0
7. 00	Income from investments				0	7.00
3. 00	Revenues from telephone and other miscellar	noous communication	sorvi cos		0	
9. 00	Revenue from television and radio service	leous communication	Sel vi ces		0	
0. 00	Purchase di scounts				0	
1. 00	Rebates and refunds of expenses				0	11.0
	Parking lot receipts				0	12.0
13.00	Revenue from Laundry and Linen service				0	13.0
4. 00	Revenue from meals sold to employees and qu	losts			0	14.0
	Revenue from rental of living quarters	lests			0	
	Revenue from sale of medical and surgical s	cupalies to other th	an nationts		0	
	Revenue from sale of drugs to other than pa		iaii pati eiits		0	
	Revenue from sale of medical records and at				0	
	Tuition (fees, sale of textbooks, uniforms,				0	19. (
0.00	Revenue from gifts, flowers, coffee shops,				0	20.0
1. 00	Rental of vending machines	and carreen			0	21. 0
2. 00	Rental of hospital space				0	
3. 00	Governmental appropriations				0	
4. 00	OTHER (SPECIFY)					
	COVI D-19 PHE Funding				1, 185, 323	1
	Total other income (sum of lines 6-24)				0 1, 185, 323	
	,					
	Total (line 5 plus line 25)				5, 680, 539	26.0
7.00	OTHER EXPENSES (SPECIFY)	shoori nto)			0	27. (
	Total other expenses (sum of line 27 and su Net income (or loss) for the period (line 2				0 5, 680, 539	
.9. 00	liver income (or ross) for the period (fine a	zo iiii ilus TTHE 28)		I	5, 080, 539	29. (

Haal th	Financial Systems STARKE	MEMODI AI	HOSPI TAL	Inlie	u of Form CMS-	2552_10
	ATION OF CAPITAL PAYMENT	WEWOK! AL	Provi der CCN: 15-0102	Peri od: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Pre 5/30/2022 10:	pared:
			Title XVIII	Hospi tal	PPS	
	DART I SHILLY PROPERTIVE METHOD				1. 00	
	PART I - FULLY PROSPECTIVE METHOD					-
1 00	CAPITAL FEDERAL AMOUNT				00 (01	1 00
1.00	Capital DRG other than outlier				98, 601	
1. 01 2. 00	Model 4 BPCI Capital DRG other than outlier				0	
2. 00	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments				0	
3. 00	Total inpatient days divided by number of days in the	s cost ro	porting pariod (see ins	tructions)	4. 90	1
4. 00	Number of interns & residents (see instructions)	e cost rep	portring perrod (see ris	ti ucti ons)	0.00	
5.00	Indirect medical education percentage (see instruction	nns)			0.00	
6. 00	Indirect medical education adjustment (multiply line		sum of lines 1 and 1 0	1 columns 1 and	0.00	
0.00	1.01) (see instructions)	5 by the	Sum of Triles I and 1.0	r, corumns r and		0.00
7. 00	Percentage of SSI recipient patient days to Medicare 30) (see instructions)	Part A pa	atient days (Worksheet	E, part A line	0. 00	7. 00
8.00	Percentage of Medicaid patient days to total days (se	e instru	rtions)		0.00	8.00
9. 00	Sum of lines 7 and 8	oc matru	211 0113)		0.00	
10. 00	Allowable disproportionate share percentage (see inst	tructions)		0.00	
11. 00	Disproportionate share adjustment (see instructions)	401. 01.0,	,		0.00	
12. 00)			98, 601	
					1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				1.00	
1.00	Program inpatient routine capital cost (see instructi	ons)			0	1.00
2.00	Program inpatient ancillary capital cost (see instruc	ctions)			0	2.00
3.00	Total inpatient program capital cost (line 1 plus lin	ne 2)			0	3.00
4.00	Capital cost payment factor (see instructions)				0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4	1)			0	5. 00
					1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				1.00	
1.00	Program inpatient capital costs (see instructions)				0	1.00
2.00	Program inpatient capital costs for extraordinary cir	cumstance	es (see instructions)		Ō	
3.00	Net program inpatient capital costs (line 1 minus lin		,		0	3.00
4.00	Applicable exception percentage (see instructions)				0.00	
5.00	Capital cost for comparison to payments (line 3 x lin	ne 4)			0	5.00
6.00	Percentage adjustment for extraordinary circumstances	s (see ins	structions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extra	aordi nary	circumstances (line 2:	x line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)				0	
9.00	Current year capital payments (from Part I, line 12,				0	
10. 00	Current year comparison of capital minimum payment le				0	
11. 00	Carryover of accumulated capital minimum payment leve Worksheet L. Part III, line 14)	el over ca	apital payment (from pr	or year	0	11. 00
12. 00	Net comparison of capital minimum payment level to ca	apital pa	yments (line 10 plus li	ne 11)	0	12. 00
13.00	Current year exception payment (if line 12 is positiv				0	13. 00
14. 00	Carryover of accumulated capital minimum payment leve (if line 12 is negative, enter the amount on this lin		apital payment for the	following period	0	14. 00

15.00 0 16.00 0 17.00

(if line 12 is negative, enter the amount on this line)

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)