This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1311	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 1/27/2022 1:36 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 1/27/2022 Time: 1:36 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FAIRFIELD MEMORIAL HOSPITAL (14-1311) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
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	Signatory Printed Name				2
3	Signatory Title				3
4	Date				4

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	332,595	-790,275	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	365		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		404,557		0	10.00
200.00	Total	0	332,595	-385,353	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 1/27/2022 1:36 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 303 NW 11TH ST	PO Box:			1.00
2.00	City: FAIRFIELD	State: IL	Zip Code: 62837	County: WAYNE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	FAIRFIELD MEMORIAL HOSPITAL	141311	99914	1	04/01/2001	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	FAIRFIELD MEMORIAL HOSPITAL	145552	99914		03/26/1985	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	FAIRFIELD MEMORIAL HOSPITAL HHA	147612	99914		05/01/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FAIRFIELD RHC	148500	99914		03/13/2009	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2020	06/30/2021	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I | Date/Time Prepared: 1/27/2022 1:36 pm

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

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

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

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 1/27/2022 1:36 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 1/27/2022 1:36 pm

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

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

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

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

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

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

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

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				V	XIX	
				1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00
			1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.		N			112.00
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2			118.00
			Premiums	Losses	Insurance	
			1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:		421,508	0	0	118.01
				1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N		118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.			N		122.00
	Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 1/27/2022 1:36 pm

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

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1311	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 1/27/2022 1:36 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part II | Date/Time Prepared: 1/27/2022 1:36 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/21/2022	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/15/2022	Y	01/15/2022	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part II Date/Time Prepared: 1/27/2022 1:36 pm

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

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA	RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314.236.5210	PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1311	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 1/27/2022 1:36 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I Date/Time Prepared: 1/27/2022 1:36 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	38,832.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	38,832.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	2,976.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	41,808.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	30	10,950		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		55				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I | Date/Time Prepared: 1/27/2022 1:36 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,101	33	1,618			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,101	33	1,618			7.00
8.00	INTENSIVE CARE UNIT	52	0	124			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,153	33	1,742	0.00	192.68	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	481	0	6,239	0.00	18.89	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3,027	0	4,566	0.00	6.36	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	7,342	4,482	24,321	0.00	41.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	258.93	27.00
28.00	Observation Bed Days		59	444			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I Date/Time Prepared: 1/27/2022 1:36 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	341	10	502	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	341	10	502	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	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	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-1311 | Component CCN: 14-7612 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-4 | Date/Time Prepared: 1/27/2022 1:36 pm

Home Health Agency I | PPS

					1.00		
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	147.00	4.00	90.00	241.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			1.83	0.00	1.83	5.00
6.00	Direct Nursing Service			2.88	0.00	2.88	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.65	0.00	0.65	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.24	0.00	0.24	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.03	0.00	0.03	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,015	633	17	0	1,665	21.00
22.00	Skilled Nursing Visit Charges	129,662	80,964	2,164	0	212,790	22.00
23.00	Physical Therapy Visits	791	155	17	0	963	23.00
24.00	Physical Therapy Visit Charges	101,164	19,822	2,176	0	123,162	24.00
25.00	Occupational Therapy Visits	269	85	6	0	360	25.00
26.00	Occupational Therapy Visit Charges	34,402	10,874	768	0	46,044	26.00
27.00	Speech Pathology Visits	34	5	0	0	39	27.00
28.00	Speech Pathology Visit Charges	4,504	665	0	0	5,169	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,109	878	40	0	3,027	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	269,732	112,325	5,108	0	387,165	35.00
36.00	Total Number of Episodes (standard/non outlier)	232		28	0	260	36.00
37.00	Total Number of Outlier Episodes		38		0	38	37.00
38.00	Total Non-Routine Medical Supply Charges	51,408	20,464	350	0	72,222	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1311 | Component CCN: 14-8500 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-8 | Date/Time Prepared: 1/27/2022 1:36 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	303 NW 11TH STREET	1.00
		City / State / ZIP Code	
		1.00 / 2.00 / 3.00	
2.00	City, State, ZIP Code, County	FAIRFIELD IL 62837	2.00
		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00
		Grant Award / Date	
		1.00 / 2.00	
	Source of Federal Funds		
4.00	Community Health Center (Section 330(d), PHS Act)		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		6.00
7.00	Appalachian Regional Commission		7.00
8.00	Look-Alikes		8.00
9.00	OTHER		9.00
		1.00 / 2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N 0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:30	05:00	08:30	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y	4	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number	FAIRFIELD RHC	148500	14.00
14.01		HORIZON HEALTHCARE	148591	14.01
14.02		HORIZON HEATLTHCARE GRAYVILLE	148602	14.02
14.03		HORIZON HEALTHCARE CARMI CLINIC	148614	14.03

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

		County	
		4.00	
2.00	City, State, ZIP Code, County	WAYNE	2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1311 | Component CCN: 14-8500 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-8 | Date/Time Prepared: 1/27/2022 1:36 pm

RHC I | Cost

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	05:00	08:30	05:00	08:30	05:00	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:30	05:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-10 | Date/Time Prepared: 1/27/2022 1:36 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.344475	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,806,009	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	19,096,485	6.00
7.00	Medicaid cost (line 1 times line 6)	6,578,262	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	3,772,253	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,772,253	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	195,540	452,147	647,687	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	67,359	452,147	519,506	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	67,359	452,147	519,506	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,575,913	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	781,956	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,203,010	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,372,903	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,582,935	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,102,441	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,874,694	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A | Date/Time Prepared: 1/27/2022 1:36 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,378,754	1,378,754	281,291	1,660,045	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		578,532	578,532	0	578,532	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,509,001	4,509,001	0	4,509,001	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,610,854	4,433,931	6,044,785	-42,968	6,001,817	5.00
6.00	00600	MAINTENANCE & REPAIRS	375,393	358,579	733,972	0	733,972	6.00
7.00	00700	OPERATION OF PLANT	0	687,710	687,710	0	687,710	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	485,434	485,434	0	485,434	8.00
9.00	00900	HOUSEKEEPING	456,939	127,621	584,560	0	584,560	9.00
10.00	01000	DIETARY	406,264	355,434	761,698	-526,257	235,441	10.00
11.00	01100	CAFETERIA	0	0	0	526,257	526,257	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	281,359	65,457	346,816	0	346,816	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	77,559	193,096	270,655	-5,472	265,183	14.00
15.00	01500	PHARMACY	240,238	1,476,652	1,716,890	0	1,716,890	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	285,141	183,742	468,883	0	468,883	16.00
17.00	01700	SOCIAL SERVICE	89,836	2,850	92,686	0	92,686	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,272,395	215,514	1,487,909	0	1,487,909	30.00
31.00	03100	INTENSIVE CARE UNIT	86,361	4,583	90,944	0	90,944	31.00
44.00	04400	SKILLED NURSING FACILITY	855,992	64,491	920,483	0	920,483	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	742,063	668,071	1,410,134	0	1,410,134	50.00
53.00	05300	ANESTHESIOLOGY	580,619	165,379	745,998	0	745,998	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	601,239	955,918	1,557,157	0	1,557,157	54.00
60.00	06000	LABORATORY	907,043	1,331,955	2,238,998	0	2,238,998	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	207,918	145,537	353,455	-68,429	285,026	65.00
66.00	06600	PHYSICAL THERAPY	705,084	15,210	720,294	-86,164	634,130	66.00
67.00	06700	OCCUPATIONAL THERAPY	129,272	0	129,272	-24,914	104,358	67.00
68.00	06800	SPEECH PATHOLOGY	120,091	23	120,114	-626	119,488	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	68,429	68,429	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,472	5,472	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	145,173	113,117	258,290	0	258,290	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,533,556	568,260	4,101,816	42,968	4,144,784	88.00
90.00	09000	CLINIC	123,906	5,027	128,933	0	128,933	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	82,125	110,291	192,416	0	192,416	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	997,843	2,160,434	3,158,277	0	3,158,277	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	336,237	90,918	427,155	111,704	538,859	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		281,291	281,291	-281,291	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,250,500	21,732,812	36,983,312	0	36,983,312	118.00
		NONREIMBURSABLE COST CENTERS						
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	329	329	0	329	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	15,250,500	21,733,141	36,983,641	0	36,983,641	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A | Date/Time Prepared: 1/27/2022 1:36 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-285,338	1,374,707		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	578,532		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-255,262	4,253,739		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,370,780	4,631,037		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	733,972		6.00
7.00	00700	OPERATION OF PLANT	0	687,710		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	485,434		8.00
9.00	00900	HOUSEKEEPING	0	584,560		9.00
10.00	01000	DIETARY	0	235,441		10.00
11.00	01100	CAFETERIA	-26,898	499,359		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	346,816		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	265,183		14.00
15.00	01500	PHARMACY	0	1,716,890		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-13,105	455,778		16.00
17.00	01700	SOCIAL SERVICE	0	92,686		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-190,329	1,297,580		30.00
31.00	03100	INTENSIVE CARE UNIT	0	90,944		31.00
44.00	04400	SKILLED NURSING FACILITY	0	920,483		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-16,957	1,393,177		50.00
53.00	05300	ANESTHESIOLOGY	-580,619	165,379		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,557,157		54.00
60.00	06000	LABORATORY	0	2,238,998		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	285,026		65.00
66.00	06600	PHYSICAL THERAPY	0	634,130		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	104,358		67.00
68.00	06800	SPEECH PATHOLOGY	0	119,488		68.00
69.00	06900	ELECTROCARDIOLOGY	-30,406	38,023		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,472		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	258,290		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-115,349	4,029,435		88.00
90.00	09000	CLINIC	0	128,933		90.00
90.01	09001	WOUND CARE	0	0		90.01
90.02	09002	CLINIC	0	192,416		90.02
90.03	09003	URGENT CARE	0	0		90.03
90.04	09004	CISNE CLINIC	0	0		90.04
91.00	09100	EMERGENCY	-1,391,082	1,767,195		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	538,859		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,276,125	32,707,187		118.00
		NONREIMBURSABLE COST CENTERS				
190.01	19001	VENDING MACHINE	0	0		190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	329		192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,276,125	32,707,516		200.00

RECLASSIFICATIONS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-6 | Date/Time Prepared: 1/27/2022 1:36 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS CAFETERIA				
1.00	CAFETERIA	11.00	280,688	245,569	1.00
	0		280,688	245,569	
	B - TO RECLASS EKG				
1.00	ELECTROCARDIOLOGY	69.00	38,023	30,406	1.00
	0		38,023	30,406	
	C - TO RECLASS INTEREST				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	281,291	1.00
	0		0	281,291	
	D - TO RECLASS IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,472	1.00
	0		0	5,472	
	E - PT OT AND ST OTHER EXPENSES				
1.00	OCCUPATIONAL THERAPY	67.00	0	1,967	1.00
2.00	SPEECH PATHOLOGY	68.00	0	1,913	2.00
	0		0	3,880	
	F - HHA THERAPISTS				
1.00	HOME HEALTH AGENCY	101.00	111,704	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		111,704	0	
	H - RHC RECRUITING EXPENSES				
1.00	RURAL HEALTH CLINIC	88.00	0	42,968	1.00
	0		0	42,968	
500.00	Grand Total: Increases		430,415	609,586	500.00

RECLASSIFICATIONS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-6 | Date/Time Prepared: 1/27/2022 1:36 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS CAFETERIA						
1.00	DIETARY	10.00	280,688	245,569	0		1.00
	0		280,688	245,569			
	B - TO RECLASS EKG						
1.00	RESPIRATORY THERAPY	65.00	38,023	30,406	0		1.00
	0		38,023	30,406			
	C - TO RECLASS INTEREST						
1.00	INTEREST EXPENSE	113.00	0	281,291	11		1.00
	0		0	281,291			
	D - TO RECLASS IMPLANTABLE DEVICES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,472	0		1.00
	0		0	5,472			
	E - PT OT AND ST OTHER EXPENSES						
1.00	PHYSICAL THERAPY	66.00	0	3,880	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	3,880			
	F - HHA THERAPISTS						
1.00	PHYSICAL THERAPY	66.00	82,284	0	0		1.00
2.00	OCCUPATIONAL THERAPY	67.00	26,881	0	0		2.00
3.00	SPEECH PATHOLOGY	68.00	2,539	0	0		3.00
	0		111,704	0			
	H - RHC RECRUITING EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	42,968	0		1.00
	0		0	42,968			
500.00	Grand Total: Decreases		430,415	609,586			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part I | Date/Time Prepared: 1/27/2022 1:36 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	449,428	0	0	0	0	1.00
2.00	Land Improvements	657,953	306,734	0	306,734	0	2.00
3.00	Buildings and Fixtures	19,910,829	0	0	0	0	3.00
4.00	Building Improvements	4,378,156	14,231,200	0	14,231,200	0	4.00
5.00	Fixed Equipment	2,164,322	22,148	0	22,148	0	5.00
6.00	Movable Equipment	15,831,649	468,238	0	468,238	0	6.00
7.00	HIT designated Assets	1,435,870	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	44,828,207	15,028,320	0	15,028,320	0	8.00
9.00	Reconciling Items	4,378,156	14,231,200	0	14,231,200	0	9.00
10.00	Total (line 8 minus line 9)	40,450,051	797,120	0	797,120	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	449,428	0	1.00
2.00	Land Improvements	964,687	0	2.00
3.00	Buildings and Fixtures	19,910,829	0	3.00
4.00	Building Improvements	18,609,356	0	4.00
5.00	Fixed Equipment	2,186,470	0	5.00
6.00	Movable Equipment	16,299,887	0	6.00
7.00	HIT designated Assets	1,435,870	0	7.00
8.00	Subtotal (sum of lines 1-7)	59,856,527	0	8.00
9.00	Reconciling Items	18,609,356	0	9.00
10.00	Total (line 8 minus line 9)	41,247,171	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part II | Date/Time Prepared: 1/27/2022 1:36 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,378,754	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	578,532	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,957,286	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,378,754	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	578,532	2.00
3.00	Total (sum of lines 1-2)	0	1,957,286	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part III Date/Time Prepared: 1/27/2022 1:36 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	42,120,770	0	42,120,770	0.703696	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,735,757	0	17,735,757	0.296304	0	2.00
3.00	Total (sum of lines 1-2)	59,856,527	0	59,856,527	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,134,767	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	578,532	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,713,299	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	239,940	0	0	0	1,374,707	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	578,532	2.00
3.00	Total (sum of lines 1-2)	239,940	0	0	0	1,953,239	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8 | Date/Time Prepared: 1/27/2022 1:36 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-41,351	CAP REL COSTS-BLDG & FIXT	1.00	11	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,138	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,079	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,209,393			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-21	ADMINISTRATIVE & GENERAL	5.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-26,898	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-13,105	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8 | Date/Time Prepared: 1/27/2022 1:36 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0	CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	VERIZON RENTAL	B	-87,073	CAP REL COSTS-BLDG & FIXT	1.00	9	33.00
33.01	RINARD & WEBER CLINIC	A	-6,914	CAP REL COSTS-BLDG & FIXT	1.00	9	33.01
33.02	RECRUITING	A	-8,891	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ADVERTISING	A	-290,344	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OTHER REVENUE	B	-63,324	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	WAYFAIR RENTAL	B	-150,000	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
33.06	PROVIDER TAX	A	-960,210	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.08	NONALLOWABLE ALCOHOL	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	OTHER EXPENSE	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.09
34.00	HOSPITALIST IN RHC SALARIES	A	-115,349	RURAL HEALTH CLINIC	88.00	0	34.00
43.00	LOBBYING PORTION OF DUES	A	-12,720	ADMINISTRATIVE & GENERAL	5.00	0	43.00
43.01	DONATIONS	A	-23,053	ADMINISTRATIVE & GENERAL	5.00	0	43.01
43.02	PHYSICIAN BENEFITS	A	-221,153	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43.02
43.03	HOSPITALIST IN RHC BENEFITS	A	-34,109	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,276,125				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-1 | Date/Time Prepared: 1/27/2022 1:36 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	54.00	RADIOLOGY-DIAGNOSTIC	MRI	214,247	214,247	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	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			214,247	214,247	5.00

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

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

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

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

6.00	G	DSSI	15.00	DSSI	15.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-1 | Date/Time Prepared: 1/27/2022 1:36 pm

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

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

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

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

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

6.00	MRI		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-2 | Date/Time Prepared: 1/27/2022 1:36 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	167,373	167,373	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	580,619	580,619	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	22,956	22,956	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	30,406	30,406	0	0	0	4.00
5.00	91.00	EMERGENCY	1,918,204	1,391,082	527,122	0	0	5.00
6.00	50.00	OPERATING ROOM	16,957	16,957	0	0	0	6.00
7.00	0.00		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			2,736,515	2,209,393	527,122		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	0.00		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			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	167,373		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	580,619		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	22,956		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	30,406		4.00
5.00	91.00	EMERGENCY	0	0	0	1,391,082		5.00
6.00	50.00	OPERATING ROOM	0	0	0	16,957		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,209,393		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I | Date/Time Prepared: 1/27/2022 1:36 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,374,707	1,374,707				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	578,532		578,532			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,253,739	0	0	4,253,739		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,631,037	235,258	99,006	476,268	5,441,569	5.00
6.00	00600	MAINTENANCE & REPAIRS	733,972	33,865	14,252	110,989	893,078	6.00
7.00	00700	OPERATION OF PLANT	687,710	22,134	9,315	0	719,159	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	485,434	15,294	6,436	0	507,164	8.00
9.00	00900	HOUSEKEEPING	584,560	2,117	891	135,099	722,667	9.00
10.00	01000	DIETARY	235,441	1,566	659	37,128	274,794	10.00
11.00	01100	CAFETERIA	499,359	46,026	19,369	82,989	647,743	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	346,816	1,531	644	83,187	432,178	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	265,183	0	0	22,931	288,114	14.00
15.00	01500	PHARMACY	1,716,890	0	0	71,029	1,787,919	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	455,778	17,614	7,413	84,305	565,110	16.00
17.00	01700	SOCIAL SERVICE	92,686	1,913	805	26,561	121,965	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,297,580	174,572	73,467	326,713	1,872,332	30.00
31.00	03100	INTENSIVE CARE UNIT	90,944	15,940	6,708	25,534	139,126	31.00
44.00	04400	SKILLED NURSING FACILITY	920,483	102,275	43,042	253,084	1,318,884	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,393,177	76,793	32,318	219,400	1,721,688	50.00
53.00	05300	ANESTHESIOLOGY	165,379	837	352	0	166,568	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,557,157	54,743	23,038	177,764	1,812,702	54.00
60.00	06000	LABORATORY	2,238,998	27,120	11,413	268,178	2,545,709	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	285,026	20,137	8,474	50,231	363,868	65.00
66.00	06600	PHYSICAL THERAPY	634,130	33,303	14,015	184,138	865,586	66.00
67.00	06700	OCCUPATIONAL THERAPY	104,358	5,788	2,436	30,273	142,855	67.00
68.00	06800	SPEECH PATHOLOGY	119,488	5,620	2,365	34,756	162,229	68.00
69.00	06900	ELECTROCARDIOLOGY	38,023	0	0	11,242	49,265	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	21,237	8,937	0	30,174	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,472	0	0	0	5,472	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,621	13,728	0	46,349	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	258,290	20,747	8,731	42,922	330,690	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,029,435	341,957	143,911	1,010,640	5,525,943	88.00
90.00	09000	CLINIC	128,933	0	0	36,634	165,567	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	192,416	12,974	5,460	24,281	235,131	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	1,767,195	27,766	11,685	295,024	2,101,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	538,859	22,959	9,662	132,439	703,919	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,707,187	1,374,707	578,532	4,253,739	32,707,187	118.00
		NONREIMBURSABLE COST CENTERS						
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	329	0	0	0	329	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,707,516	1,374,707	578,532	4,253,739	32,707,516	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I | Date/Time Prepared: 1/27/2022 1:36 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,441,569					5.00
6.00	00600	MAINTENANCE & REPAIRS	178,235	1,071,313				6.00
7.00	00700	OPERATION OF PLANT	143,525	21,448	884,132			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	101,217	14,820	12,480	635,681		8.00
9.00	00900	HOUSEKEEPING	144,226	2,051	1,727	197,675	1,068,346	9.00
10.00	01000	DIETARY	54,842	1,518	1,278	3,002	1,570	10.00
11.00	01100	CAFETERIA	129,273	44,599	37,558	0	46,125	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	86,251	1,483	1,249	0	1,534	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	57,500	0	0	0	0	14.00
15.00	01500	PHARMACY	356,822	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	112,781	17,068	14,374	0	17,652	16.00
17.00	01700	SOCIAL SERVICE	24,341	1,854	1,561	0	1,917	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	373,669	169,161	142,457	93,201	174,950	30.00
31.00	03100	INTENSIVE CARE UNIT	27,766	15,446	13,007	1,301	15,974	31.00
44.00	04400	SKILLED NURSING FACILITY	263,215	99,105	83,460	91,951	102,497	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	343,604	74,413	62,666	88,936	76,959	50.00
53.00	05300	ANESTHESIOLOGY	33,243	811	683	0	839	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	361,768	53,046	44,672	36,667	54,861	54.00
60.00	06000	LABORATORY	508,057	26,280	22,131	4,380	27,179	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	72,619	19,513	16,432	6,596	20,181	65.00
66.00	06600	PHYSICAL THERAPY	172,748	32,270	27,176	8,181	33,375	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,510	5,608	4,723	1,417	5,800	67.00
68.00	06800	SPEECH PATHOLOGY	32,377	5,446	4,586	1,379	5,632	68.00
69.00	06900	ELECTROCARDIOLOGY	9,832	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,022	20,579	17,330	0	21,283	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,092	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,250	31,610	26,620	0	32,692	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	65,997	20,104	16,930	0	20,792	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,102,829	331,356	279,052	12,046	342,697	88.00
90.00	09000	CLINIC	33,043	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	46,926	12,572	10,587	0	13,002	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	419,439	26,905	22,658	88,949	27,826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	140,484	22,247	18,735	0	23,009	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,441,503	1,071,313	884,132	635,681	1,068,346	118.00
		NONREIMBURSABLE COST CENTERS						
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	66	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,441,569	1,071,313	884,132	635,681	1,068,346	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I | Date/Time Prepared: 1/27/2022 1:36 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	337,004					10.00
11.00	01100	CAFETERIA	0	905,298				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	21,351	0	544,046		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,902	0	0	355,516	14.00
15.00	01500	PHARMACY	0	16,348	0	18,255	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	38,267	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	8,458	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	82,484	110,313	0	123,254	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,958	7,684	0	8,604	0	31.00
44.00	04400	SKILLED NURSING FACILITY	249,562	97,420	0	108,824	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	41,361	0	46,183	0	50.00
53.00	05300	ANESTHESIOLOGY	0	32,336	0	36,136	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	55,182	0	0	0	54.00
60.00	06000	LABORATORY	0	105,929	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	17,328	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	45,745	0	51,109	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,962	0	7,767	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,343	0	7,103	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,816	0	4,260	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	342,479	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	13,037	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	15,730	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	164,257	0	0	0	88.00
90.00	09000	CLINIC	0	6,292	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	8,458	0	0	0	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	85,816	0	95,888	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	36,663	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	337,004	905,298	0	544,046	355,516	118.00
		NONREIMBURSABLE COST CENTERS						
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
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)	337,004	905,298	0	544,046	355,516	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I | Date/Time Prepared: 1/27/2022 1:36 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	2,179,344					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	765,252				16.00
17.00	01700	SOCIAL SERVICE	0	0	160,096			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	42,257	32,883	0	3,216,961	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,877	0	0	235,743	31.00
44.00	04400	SKILLED NURSING FACILITY	0	9,005	25,202	0	2,449,125	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	108,233	0	0	2,564,043	50.00
53.00	05300	ANESTHESIOLOGY	0	512	0	0	271,128	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	182,541	0	0	2,601,439	54.00
60.00	06000	LABORATORY	0	172,070	0	0	3,411,735	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	29,104	0	0	545,641	65.00
66.00	06600	PHYSICAL THERAPY	0	16,391	0	0	1,252,581	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,846	0	0	206,488	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,767	0	0	227,862	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,871	0	0	77,044	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	36,010	0	0	473,877	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,371	0	0	20,972	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,179,344	62,674	0	0	2,388,539	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	11,169	0	0	481,412	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	43,323	0	0	7,801,503	88.00
90.00	09000	CLINIC	0	1,588	0	0	206,490	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	2,348	0	0	329,024	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	29,295	102,011	0	3,000,457	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	945,057	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,179,344	765,252	160,096	0	32,707,121	118.00
		NONREIMBURSABLE COST CENTERS						
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	395	192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,179,344	765,252	160,096	0	32,707,516	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I | Date/Time Prepared: 1/27/2022 1:36 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,216,961		30.00
31.00	03100	INTENSIVE CARE UNIT	0	235,743		31.00
44.00	04400	SKILLED NURSING FACILITY	0	2,449,125		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,564,043		50.00
53.00	05300	ANESTHESIOLOGY	0	271,128		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,601,439		54.00
60.00	06000	LABORATORY	0	3,411,735		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	545,641		65.00
66.00	06600	PHYSICAL THERAPY	0	1,252,581		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	206,488		67.00
68.00	06800	SPEECH PATHOLOGY	0	227,862		68.00
69.00	06900	ELECTROCARDIOLOGY	0	77,044		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	473,877		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,972		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,388,539		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	481,412		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	7,801,503		88.00
90.00	09000	CLINIC	0	206,490		90.00
90.01	09001	WOUND CARE	0	0		90.01
90.02	09002	CLINIC	0	329,024		90.02
90.03	09003	URGENT CARE	0	0		90.03
90.04	09004	CISNE CLINIC	0	0		90.04
91.00	09100	EMERGENCY	0	3,000,457		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	945,057		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	32,707,121		118.00
		NONREIMBURSABLE COST CENTERS				
190.01	19001	VENDING MACHINE	0	0		190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	395		192.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	32,707,516		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II Date/Time Prepared: 1/27/2022 1:36 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	235,258	99,006	334,264	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	33,865	14,252	48,117	0	6.00
7.00	00700	OPERATION OF PLANT	0	22,134	9,315	31,449	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,294	6,436	21,730	0	8.00
9.00	00900	HOUSEKEEPING	0	2,117	891	3,008	0	9.00
10.00	01000	DIETARY	0	1,566	659	2,225	0	10.00
11.00	01100	CAFETERIA	0	46,026	19,369	65,395	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,531	644	2,175	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,614	7,413	25,027	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,913	805	2,718	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	174,572	73,467	248,039	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	15,940	6,708	22,648	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	102,275	43,042	145,317	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	76,793	32,318	109,111	0	50.00
53.00	05300	ANESTHESIOLOGY	0	837	352	1,189	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,743	23,038	77,781	0	54.00
60.00	06000	LABORATORY	0	27,120	11,413	38,533	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	20,137	8,474	28,611	0	65.00
66.00	06600	PHYSICAL THERAPY	0	33,303	14,015	47,318	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,788	2,436	8,224	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,620	2,365	7,985	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	21,237	8,937	30,174	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,621	13,728	46,349	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	20,747	8,731	29,478	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	341,957	143,911	485,868	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	12,974	5,460	18,434	0	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	27,766	11,685	39,451	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	22,959	9,662	32,621	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,374,707	578,532	1,953,239	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,374,707	578,532	1,953,239	0	202.00

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		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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	334,264					5.00
6.00	00600	MAINTENANCE & REPAIRS	10,948	59,065				6.00
7.00	00700	OPERATION OF PLANT	8,816	1,182	41,447			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,217	817	585	29,349		8.00
9.00	00900	HOUSEKEEPING	8,859	113	81	9,126	21,187	9.00
10.00	01000	DIETARY	3,369	84	60	139	31	10.00
11.00	01100	CAFETERIA	7,941	2,459	1,761	0	915	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	5,298	82	59	0	30	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,532	0	0	0	0	14.00
15.00	01500	PHARMACY	21,918	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,928	941	674	0	350	16.00
17.00	01700	SOCIAL SERVICE	1,495	102	73	0	38	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,953	9,326	6,678	4,303	3,470	30.00
31.00	03100	INTENSIVE CARE UNIT	1,706	852	610	60	317	31.00
44.00	04400	SKILLED NURSING FACILITY	16,168	5,464	3,913	4,245	2,033	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,106	4,103	2,938	4,106	1,526	50.00
53.00	05300	ANESTHESIOLOGY	2,042	45	32	0	17	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,222	2,925	2,094	1,693	1,088	54.00
60.00	06000	LABORATORY	31,208	1,449	1,037	202	539	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,461	1,076	770	305	400	65.00
66.00	06600	PHYSICAL THERAPY	10,611	1,779	1,274	378	662	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,751	309	221	65	115	67.00
68.00	06800	SPEECH PATHOLOGY	1,989	300	215	64	112	68.00
69.00	06900	ELECTROCARDIOLOGY	604	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	370	1,135	812	0	422	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	67	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	568	1,743	1,248	0	648	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,054	1,108	794	0	412	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	67,754	18,268	13,082	556	6,796	88.00
90.00	09000	CLINIC	2,030	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	2,882	693	496	0	258	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	25,764	1,483	1,062	4,107	552	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	8,629	1,227	878	0	456	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	334,260	59,065	41,447	29,349	21,187	118.00
		NONREIMBURSABLE COST CENTERS						
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	4	0	0	0	0	192.00
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)	334,264	59,065	41,447	29,349	21,187	202.00

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		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	5,908					10.00
11.00	01100	CAFETERIA	0	78,471				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,851	0	9,495		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	858	0	0	4,390	14.00
15.00	01500	PHARMACY	0	1,417	0	319	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,317	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	733	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,446	9,562	0	2,151	0	30.00
31.00	03100	INTENSIVE CARE UNIT	87	666	0	150	0	31.00
44.00	04400	SKILLED NURSING FACILITY	4,375	8,444	0	1,899	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,585	0	806	0	50.00
53.00	05300	ANESTHESIOLOGY	0	2,803	0	631	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,783	0	0	0	54.00
60.00	06000	LABORATORY	0	9,182	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,502	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,965	0	892	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	603	0	136	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	550	0	124	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	331	0	74	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	4,229	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	161	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,363	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	14,239	0	0	0	88.00
90.00	09000	CLINIC	0	545	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	733	0	0	0	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	7,439	0	1,673	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	640	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,908	78,471	0	9,495	4,390	118.00
		NONREIMBURSABLE COST CENTERS						
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,908	78,471	0	9,495	4,390	202.00

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		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	23,654					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	37,237				16.00
17.00	01700	SOCIAL SERVICE	0	0	5,159			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,054	1,060		311,042	30.00
31.00	03100	INTENSIVE CARE UNIT	0	91	0		27,187	31.00
44.00	04400	SKILLED NURSING FACILITY	0	438	812		193,108	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,260	0		152,541	50.00
53.00	05300	ANESTHESIOLOGY	0	25	0		6,784	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,916	0		121,502	54.00
60.00	06000	LABORATORY	0	8,363	0		90,513	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,414	0		38,539	65.00
66.00	06600	PHYSICAL THERAPY	0	797	0		67,676	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	138	0		11,562	67.00
68.00	06800	SPEECH PATHOLOGY	0	134	0		11,473	68.00
69.00	06900	ELECTROCARDIOLOGY	0	480	0		1,489	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,750	0		38,892	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	67	0		295	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,654	3,046	0		77,256	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	543	0		37,752	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,106	0		608,669	88.00
90.00	09000	CLINIC	0	77	0		2,652	90.00
90.01	09001	WOUND CARE	0	0	0		0	90.01
90.02	09002	CLINIC	0	114	0		23,610	90.02
90.03	09003	URGENT CARE	0	0	0		0	90.03
90.04	09004	CISNE CLINIC	0	0	0		0	90.04
91.00	09100	EMERGENCY	0	1,424	3,287		86,242	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0		0	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0		44,451	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,654	37,237	5,159	0	1,953,235	118.00
		NONREIMBURSABLE COST CENTERS						
190.01	19001	VENDING MACHINE	0	0	0		0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0		4	192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	23,654	37,237	5,159	0	1,953,239	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II | Date/Time Prepared: 1/27/2022 1:36 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	311,042		30.00
31.00	03100	INTENSIVE CARE UNIT	0	27,187		31.00
44.00	04400	SKILLED NURSING FACILITY	0	193,108		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	152,541		50.00
53.00	05300	ANESTHESIOLOGY	0	6,784		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	121,502		54.00
60.00	06000	LABORATORY	0	90,513		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	38,539		65.00
66.00	06600	PHYSICAL THERAPY	0	67,676		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,562		67.00
68.00	06800	SPEECH PATHOLOGY	0	11,473		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,489		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	38,892		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	295		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	77,256		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	37,752		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	608,669		88.00
90.00	09000	CLINIC	0	2,652		90.00
90.01	09001	WOUND CARE	0	0		90.01
90.02	09002	CLINIC	0	23,610		90.02
90.03	09003	URGENT CARE	0	0		90.03
90.04	09004	CISNE CLINIC	0	0		90.04
91.00	09100	EMERGENCY	0	86,242		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	44,451		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,953,235		118.00
		NONREIMBURSABLE COST CENTERS				
190.01	19001	VENDING MACHINE	0	0		190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	4		192.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,953,239		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 1/27/2022 1:36 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	114,963					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		114,963				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	14,387,159			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,674	19,674	1,610,854	-5,441,569	27,265,947	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,832	2,832	375,393	0	893,078	6.00
7.00	00700	OPERATION OF PLANT	1,851	1,851	0	0	719,159	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,279	1,279	0	0	507,164	8.00
9.00	00900	HOUSEKEEPING	177	177	456,939	0	722,667	9.00
10.00	01000	DIETARY	131	131	125,576	0	274,794	10.00
11.00	01100	CAFETERIA	3,849	3,849	280,688	0	647,743	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	128	128	281,359	0	432,178	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	77,559	0	288,114	14.00
15.00	01500	PHARMACY	0	0	240,238	0	1,787,919	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,473	1,473	285,141	0	565,110	16.00
17.00	01700	SOCIAL SERVICE	160	160	89,836	0	121,965	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,599	14,599	1,105,022	0	1,872,332	30.00
31.00	03100	INTENSIVE CARE UNIT	1,333	1,333	86,361	0	139,126	31.00
44.00	04400	SKILLED NURSING FACILITY	8,553	8,553	855,992	0	1,318,884	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,422	6,422	742,063	0	1,721,688	50.00
53.00	05300	ANESTHESIOLOGY	70	70	0	0	166,568	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,578	4,578	601,239	0	1,812,702	54.00
60.00	06000	LABORATORY	2,268	2,268	907,043	0	2,545,709	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,684	1,684	169,895	0	363,868	65.00
66.00	06600	PHYSICAL THERAPY	2,785	2,785	622,800	0	865,586	66.00
67.00	06700	OCCUPATIONAL THERAPY	484	484	102,391	0	142,855	67.00
68.00	06800	SPEECH PATHOLOGY	470	470	117,552	0	162,229	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	38,023	0	49,265	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,776	1,776	0	0	30,174	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,472	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,728	2,728	0	0	46,349	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,735	1,735	145,173	0	330,690	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	28,597	28,597	3,418,207	0	5,525,943	88.00
90.00	09000	CLINIC	0	0	123,906	0	165,567	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	1,085	1,085	82,125	0	235,131	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	2,322	2,322	997,843	0	2,101,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,920	1,920	447,941	0	703,919	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,963	114,963	14,387,159	-5,441,569	27,265,618	118.00
		NONREIMBURSABLE COST CENTERS						
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	329	192.00
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)	1,374,707	578,532	4,253,739		5,441,569	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.957821	5.032332	0.295662		0.199574	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		334,264	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.012259	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 1/27/2022 1:36 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	92,457					6.00
7.00	00700	OPERATION OF PLANT	1,851	90,606				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,279	1,279	49,340			8.00
9.00	00900	HOUSEKEEPING	177	177	15,343	89,150		9.00
10.00	01000	DIETARY	131	131	233	131	42,683	10.00
11.00	01100	CAFETERIA	3,849	3,849	0	3,849	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	128	128	0	128	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,473	1,473	0	1,473	0	16.00
17.00	01700	SOCIAL SERVICE	160	160	0	160	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,599	14,599	7,234	14,599	10,447	30.00
31.00	03100	INTENSIVE CARE UNIT	1,333	1,333	101	1,333	628	31.00
44.00	04400	SKILLED NURSING FACILITY	8,553	8,553	7,137	8,553	31,608	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,422	6,422	6,903	6,422	0	50.00
53.00	05300	ANESTHESIOLOGY	70	70	0	70	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,578	4,578	2,846	4,578	0	54.00
60.00	06000	LABORATORY	2,268	2,268	340	2,268	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,684	1,684	512	1,684	0	65.00
66.00	06600	PHYSICAL THERAPY	2,785	2,785	635	2,785	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	484	484	110	484	0	67.00
68.00	06800	SPEECH PATHOLOGY	470	470	107	470	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,776	1,776	0	1,776	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,728	2,728	0	2,728	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,735	1,735	0	1,735	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	28,597	28,597	935	28,597	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	1,085	1,085	0	1,085	0	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	2,322	2,322	6,904	2,322	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,920	1,920	0	1,920	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92,457	90,606	49,340	89,150	42,683	118.00
		NONREIMBURSABLE COST CENTERS						
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
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)	1,071,313	884,132	635,681	1,068,346	337,004	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.587149	9.757985	12.883685	11.983690	7.895509	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	59,065	41,447	29,349	21,187	5,908	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.638838	0.457442	0.594832	0.237656	0.138416	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 1/27/2022 1:36 pm

		Cost Center Description	CAFETERIA (FTES SERV ED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS ING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS.)	PHARMACY (COSTED REQ UIS.)	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	17,554					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	414	0	196,398			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	192	0	0	4,610,970		14.00
15.00	01500	PHARMACY	317	0	6,590	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	742	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	164	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,139	0	44,494	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	149	0	3,106	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	1,889	0	39,285	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	802	0	16,672	0	0	50.00
53.00	05300	ANESTHESIOLOGY	627	0	13,045	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,070	0	0	0	0	54.00
60.00	06000	LABORATORY	2,054	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	336	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	887	0	18,450	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	135	0	2,804	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	123	0	2,564	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	74	0	1,538	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,441,879	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	169,091	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	305	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,185	0	0	0	0	88.00
90.00	09000	CLINIC	122	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	164	0	0	0	0	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	1,664	0	34,615	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	13,235	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,554	0	196,398	4,610,970	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
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)	905,298	0	544,046	355,516	2,179,344	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	51.572177	0.000000	2.770120	0.077102	21,793.440000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	78,471	0	9,495	4,390	23,654	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.470263	0.000000	0.048346	0.000952	236.540000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 1/27/2022 1:36 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (ASSIGNED TIME)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	94,398,888				16.00
17.00	01700	SOCIAL SERVICE	0	11,047			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,212,369	2,269	0		30.00
31.00	03100	INTENSIVE CARE UNIT	231,577	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	1,110,766	1,739	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	13,350,541	0	0		50.00
53.00	05300	ANESTHESIOLOGY	63,130	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,521,323	0	0		54.00
60.00	06000	LABORATORY	21,224,919	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	3,589,940	0	0		65.00
66.00	06600	PHYSICAL THERAPY	2,021,825	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	351,020	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	341,367	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	1,217,600	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,441,879	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	169,091	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,730,828	0	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,377,645	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	5,343,960	0	0		88.00
90.00	09000	CLINIC	195,889	0	0		90.00
90.01	09001	WOUND CARE	0	0	0		90.01
90.02	09002	CLINIC	289,679	0	0		90.02
90.03	09003	URGENT CARE	0	0	0		90.03
90.04	09004	CISNE CLINIC	0	0	0		90.04
91.00	09100	EMERGENCY	3,613,540	7,039	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0		93.99
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	94,398,888	11,047	0		118.00
		NONREIMBURSABLE COST CENTERS					
190.01	19001	VENDING MACHINE	0	0	0		190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0		192.00
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)	765,252	160,096	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.008107	14.492260	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	37,237	5,159	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000394	0.467005	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,216,961		3,216,961	0	3,216,961	30.00
31.00	03100	INTENSIVE CARE UNIT	235,743		235,743	0	235,743	31.00
44.00	04400	SKILLED NURSING FACILITY	2,449,125		2,449,125	0	2,449,125	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,564,043		2,564,043	0	2,564,043	50.00
53.00	05300	ANESTHESIOLOGY	271,128		271,128	0	271,128	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,601,439		2,601,439	0	2,601,439	54.00
60.00	06000	LABORATORY	3,411,735		3,411,735	0	3,411,735	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	545,641	0	545,641	0	545,641	65.00
66.00	06600	PHYSICAL THERAPY	1,252,581	0	1,252,581	0	1,252,581	66.00
67.00	06700	OCCUPATIONAL THERAPY	206,488	0	206,488	0	206,488	67.00
68.00	06800	SPEECH PATHOLOGY	227,862	0	227,862	0	227,862	68.00
69.00	06900	ELECTROCARDIOLOGY	77,044		77,044	0	77,044	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	473,877		473,877	0	473,877	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,972		20,972	0	20,972	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,388,539		2,388,539	0	2,388,539	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	481,412		481,412	0	481,412	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,801,503		7,801,503	0	7,801,503	88.00
90.00	09000	CLINIC	206,490		206,490	0	206,490	90.00
90.01	09001	WOUND CARE	0		0	0	0	90.01
90.02	09002	CLINIC	329,024		329,024	0	329,024	90.02
90.03	09003	URGENT CARE	0		0	0	0	90.03
90.04	09004	CISNE CLINIC	0		0	0	0	90.04
91.00	09100	EMERGENCY	3,000,457		3,000,457	0	3,000,457	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	692,693		692,693		692,693	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	945,057		945,057		945,057	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	33,399,814	0	33,399,814	0	33,399,814	200.00
201.00		Less Observation Beds	692,693		692,693		692,693	201.00
202.00		Total (see instructions)	32,707,121	0	32,707,121	0	32,707,121	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,516,508		4,516,508			30.00
31.00	03100	INTENSIVE CARE UNIT	231,577		231,577			31.00
44.00	04400	SKILLED NURSING FACILITY	1,110,766		1,110,766			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,174,841	12,175,700	13,350,541	0.192055	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	7,020	56,110	63,130	4.294757	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	954,164	21,567,159	22,521,323	0.115510	0.000000	54.00
60.00	06000	LABORATORY	1,718,115	19,506,804	21,224,919	0.160742	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	1,728,477	1,861,463	3,589,940	0.151992	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	214,342	1,807,483	2,021,825	0.619530	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	222,540	128,480	351,020	0.588251	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	30,114	311,253	341,367	0.667499	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	113,765	1,103,835	1,217,600	0.063275	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	692,765	3,749,114	4,441,879	0.106684	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,301	162,790	169,091	0.124028	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,233,760	4,497,068	7,730,828	0.308963	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,377,645	1,377,645	0.349446	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,343,960	5,343,960			88.00
90.00	09000	CLINIC	0	195,889	195,889	1.054117	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	289,679	289,679	1.135823	0.000000	90.02
90.03	09003	URGENT CARE	0	0	0	0.000000	0.000000	90.03
90.04	09004	CISNE CLINIC	0	0	0	0.000000	0.000000	90.04
91.00	09100	EMERGENCY	89,680	3,523,860	3,613,540	0.830337	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	57,930	637,931	695,861	0.995447	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	548,822	548,822			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	16,102,665	78,845,045	94,947,710			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	16,102,665	78,845,045	94,947,710			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.192055		50.00
53.00	05300	ANESTHESIOLOGY	4.294757		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.115510		54.00
60.00	06000	LABORATORY	0.160742		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.151992		65.00
66.00	06600	PHYSICAL THERAPY	0.619530		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.588251		67.00
68.00	06800	SPEECH PATHOLOGY	0.667499		68.00
69.00	06900	ELECTROCARDIOLOGY	0.063275		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.106684		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.124028		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.308963		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.349446		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	1.054117		90.00
90.01	09001	WOUND CARE	0.000000		90.01
90.02	09002	CLINIC	1.135823		90.02
90.03	09003	URGENT CARE	0.000000		90.03
90.04	09004	CISNE CLINIC	0.000000		90.04
91.00	09100	EMERGENCY	0.830337		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.995447		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		93.99
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 1/27/2022 1:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,216,961		3,216,961	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	235,743		235,743	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	2,449,125		2,449,125	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,564,043		2,564,043	0	0	50.00
53.00	05300	ANESTHESIOLOGY	271,128		271,128	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,601,439		2,601,439	0	0	54.00
60.00	06000	LABORATORY	3,411,735		3,411,735	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	545,641	0	545,641	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,252,581	0	1,252,581	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	206,488	0	206,488	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	227,862	0	227,862	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	77,044		77,044	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	473,877		473,877	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,972		20,972	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,388,539		2,388,539	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	481,412		481,412	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,801,503		7,801,503	0	0	88.00
90.00	09000	CLINIC	206,490		206,490	0	0	90.00
90.01	09001	WOUND CARE	0		0	0	0	90.01
90.02	09002	CLINIC	329,024		329,024	0	0	90.02
90.03	09003	URGENT CARE	0		0	0	0	90.03
90.04	09004	CISNE CLINIC	0		0	0	0	90.04
91.00	09100	EMERGENCY	3,000,457		3,000,457	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	945,057		945,057		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	32,707,121	0	32,707,121	0	0	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	32,707,121	0	32,707,121	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 1/27/2022 1:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	URGENT CARE	0	0	0	0.000000	0.000000	90.03
90.04	09004	CISNE CLINIC	0	0	0	0.000000	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	0	0	0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 1/27/2022 1:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CARE	0.000000		90.01
90.02	09002	CLINIC	0.000000		90.02
90.03	09003	URGENT CARE	0.000000		90.03
90.04	09004	CISNE CLINIC	0.000000		90.04
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		93.99
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part II Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	152,541	13,350,541	0.011426	529,438	6,049	50.00
53.00	05300	ANESTHESIOLOGY	6,784	63,130	0.107461	7,020	754	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	121,502	22,521,323	0.005395	658,969	3,555	54.00
60.00	06000	LABORATORY	90,513	21,224,919	0.004264	1,140,589	4,863	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	38,539	3,589,940	0.010735	910,038	9,769	65.00
66.00	06600	PHYSICAL THERAPY	67,676	2,021,825	0.033473	41,783	1,399	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,562	351,020	0.032938	34,338	1,131	67.00
68.00	06800	SPEECH PATHOLOGY	11,473	341,367	0.033609	12,332	414	68.00
69.00	06900	ELECTROCARDIOLOGY	1,489	1,217,600	0.001223	71,617	88	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	38,892	4,441,879	0.008756	655,295	5,738	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	295	169,091	0.001745	1,086	2	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,256	7,730,828	0.009993	1,842,152	18,409	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	37,752	1,377,645	0.027403	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	608,669	5,343,960	0.113898	0	0	88.00
90.00	09000	CLINIC	2,652	195,889	0.013538	0	0	90.00
90.01	09001	WOUND CARE	0	0	0.000000	0	0	90.01
90.02	09002	CLINIC	23,610	289,679	0.081504	0	0	90.02
90.03	09003	URGENT CARE	0	0	0.000000	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0.000000	0	0	90.04
91.00	09100	EMERGENCY	86,242	3,613,540	0.023866	51,676	1,233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	66,975	695,861	0.096248	25,988	2,501	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00		Total (lines 50 through 199)	1,444,422	88,540,037		5,982,321	55,905	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV | Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	13,350,541	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	63,130	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,521,323	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	21,224,919	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,589,940	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,021,825	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	351,020	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	341,367	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,217,600	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,441,879	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	169,091	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,730,828	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,377,645	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,343,960	0.000000	88.00
90.00	09000	CLINIC	0	0	0	195,889	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	0	0	289,679	0.000000	90.02
90.03	09003	URGENT CARE	0	0	0	0	0.000000	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	3,613,540	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	695,861	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	88,540,037		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	529,438	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	7,020	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	658,969	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,140,589	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	910,038	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	41,783	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	34,338	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	12,332	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	71,617	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	655,295	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,086	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,842,152	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	URGENT CARE	0.000000	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	51,676	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	25,988	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		5,982,321	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.192055	0	3,965,439	0	0	50.00
53.00	05300	ANESTHESIOLOGY	4.294757	0	13,923	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.115510	0	9,974,044	0	0	54.00
60.00	06000	LABORATORY	0.160742	0	6,903,489	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.151992	0	757,327	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.619530	0	660,200	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.588251	0	21,382	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.667499	0	27,468	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063275	0	584,072	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.106684	0	1,379,698	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.124028	0	103,775	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.308963	0	2,400,011	195,198	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.349446	0	1,326,756	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	1.054117	0	0	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	1.135823	0	94,712	0	0	90.02
90.03	09003	URGENT CARE	0.000000	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.830337	0	1,297,407	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.995447	0	234,901	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Subtotal (see instructions)		0	29,744,604	195,198	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	29,744,604	195,198	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	761,582	0		50.00
53.00	05300	ANESTHESIOLOGY	59,796	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,152,102	0		54.00
60.00	06000	LABORATORY	1,109,681	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	115,108	0		65.00
66.00	06600	PHYSICAL THERAPY	409,014	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	12,578	0		67.00
68.00	06800	SPEECH PATHOLOGY	18,335	0		68.00
69.00	06900	ELECTROCARDIOLOGY	36,957	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	147,192	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,871	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	741,515	60,309		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	463,630	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CARE	0	0		90.01
90.02	09002	CLINIC	107,576	0		90.02
90.03	09003	URGENT CARE	0	0		90.03
90.04	09004	CISNE CLINIC	0	0		90.04
91.00	09100	EMERGENCY	1,077,285	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	233,831	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	6,459,053	60,309		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,459,053	60,309		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1311 | Component CCN: 14-5552 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.192055	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	4.294757	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.115510	0	0	0	0	54.00
60.00	06000	LABORATORY	0.160742	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.151992	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.619530	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.588251	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.667499	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063275	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.106684	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.124028	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.308963	0	0	4,189	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.349446	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	1.054117	0	0	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	1.135823	0	0	0	0	90.02
90.03	09003	URGENT CARE	0.000000	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.830337	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.995447	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Subtotal (see instructions)		0	0	4,189	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	4,189	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1311 | Component CCN: 14-5552 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V | Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,294		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CARE	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	URGENT CARE	0	0		90.03
90.04	09004	CISNE CLINIC	0	0		90.04
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	0	1,294		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,294		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part I Date/Time Prepared: 1/27/2022 1:36 pm

Title XIX | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	311,042	0	311,042	2,062	150.84	30.00
31.00	INTENSIVE CARE UNIT	27,187		27,187	124	219.25	31.00
44.00	SKILLED NURSING FACILITY	193,108		193,108	6,239	30.95	44.00
200.00	Total (lines 30 through 199)	531,337		531,337	8,425		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	33	4,978	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	33	4,978	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part II Date/Time Prepared: 1/27/2022 1:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	152,541	0	0.000000	0	0	50.00
53.00	05300	ANESTHESIOLOGY	6,784	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	121,502	0	0.000000	0	0	54.00
60.00	06000	LABORATORY	90,513	0	0.000000	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	38,539	0	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	67,676	0	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,562	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,473	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,489	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	38,892	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	295	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,256	0	0.000000	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	37,752	0	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	608,669	0	0.000000	0	0	88.00
90.00	09000	CLINIC	2,652	0	0.000000	0	0	90.00
90.01	09001	WOUND CARE	0	0	0.000000	0	0	90.01
90.02	09002	CLINIC	23,610	0	0.000000	0	0	90.02
90.03	09003	URGENT CARE	0	0	0.000000	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0.000000	0	0	90.04
91.00	09100	EMERGENCY	86,242	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00		Total (lines 50 through 199)	1,377,447	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part III Date/Time Prepared: 1/27/2022 1:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,062	0.00	33	30.00
31.00	03100	INTENSIVE CARE UNIT		0	124	0.00	0	31.00
44.00	04400	SKILLED NURSING FACILITY		0	6,239	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	8,425		33	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV | Date/Time Prepared: 1/27/2022 1:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 1/27/2022 1:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	URGENT CARE	0	0	0	0	0.000000	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 1/27/2022 1:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	URGENT CARE	0.000000	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,062	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,062	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,618	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,101	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,216,961	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,216,961	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,216,961	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,560.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,717,692	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,717,692	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	235,743	124	1,901.15	52	98,860	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,296,435	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,112,987	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	444	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,560.12	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	692,693	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	311,042	3,216,961	0.096688	692,693	66,975	90.00
91.00	Nursing Program cost	0	3,216,961	0.000000	692,693	0	91.00
92.00	Allied health cost	0	3,216,961	0.000000	692,693	0	92.00
93.00	All other Medical Education	0	3,216,961	0.000000	692,693	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1311 Component CCN: 14-5552	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 1/27/2022 1:36 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,239	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,239	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	6,239	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	481	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,449,125	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,449,125	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,449,125	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1311 | Component CCN: 14-5552 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,449,125	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	392.55	71.00
72.00	Program routine service cost (line 9 x line 71)	188,817	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	188,817	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	188,817	83.00
84.00	Program inpatient ancillary services (see instructions)	195,369	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	384,186	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1311 Component CCN: 14-5552	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 1/27/2022 1:36 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,498,717		30.00
31.00	03100	INTENSIVE CARE UNIT		116,630		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.192055	529,438	101,681	50.00
53.00	05300	ANESTHESIOLOGY	4.294757	7,020	30,149	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.115510	658,969	76,118	54.00
60.00	06000	LABORATORY	0.160742	1,140,589	183,341	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.151992	910,038	138,318	65.00
66.00	06600	PHYSICAL THERAPY	0.619530	41,783	25,886	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.588251	34,338	20,199	67.00
68.00	06800	SPEECH PATHOLOGY	0.667499	12,332	8,232	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063275	71,617	4,532	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.106684	655,295	69,909	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.124028	1,086	135	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.308963	1,842,152	569,157	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.349446	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.054117	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	90.01
90.02	09002	CLINIC	1.135823	0	0	90.02
90.03	09003	URGENT CARE	0.000000	0	0	90.03
90.04	09004	CISNE CLINIC	0.000000	0	0	90.04
91.00	09100	EMERGENCY	0.830337	51,676	42,908	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.995447	25,988	25,870	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,982,321	1,296,435	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		5,982,321		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1311 | Component CCN: 14-5552 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.192055	0	0	50.00
53.00	05300	ANESTHESIOLOGY	4.294757	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.115510	6,124	707	54.00
60.00	06000	LABORATORY	0.160742	35,518	5,709	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.151992	33,498	5,091	65.00
66.00	06600	PHYSICAL THERAPY	0.619530	114,645	71,026	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.588251	138,160	81,273	67.00
68.00	06800	SPEECH PATHOLOGY	0.667499	5,025	3,354	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063275	313	20	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.106684	37,470	3,997	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.124028	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.308963	78,300	24,192	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.349446	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.054117	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	90.01
90.02	09002	CLINIC	1.135823	0	0	90.02
90.03	09003	URGENT CARE	0.000000	0	0	90.03
90.04	09004	CISNE CLINIC	0.000000	0	0	90.04
91.00	09100	EMERGENCY	0.830337	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.995447	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		449,053	195,369	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		449,053		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1311	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 1/27/2022 1:36 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,519,362	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,519,362	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,584,556	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	100,983	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,438,922	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,044,651	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,044,651	30.00
31.00	Primary payer payments	995	31.00
32.00	Subtotal (line 30 minus line 31)	2,043,656	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	1,084,680	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	705,042	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	849,392	36.00
37.00	Subtotal (see instructions)	2,748,698	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,748,698	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,538,973	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-790,275	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1311 Component CCN: 14-5552	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 1/27/2022 1:36 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,294	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
4.01	Outlier reconciliation amount (see instructions)		4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,294	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	4,189	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)	4,189	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	4,189	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,895	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	1,294	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,294	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,294	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,294	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,294	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,294	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	929	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	365	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-1 Part I Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,169,797		3,325,173	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	04/29/2021	308,700	04/29/2021	213,800	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		308,700		213,800	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,478,497		3,538,973	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		332,595		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		790,275	6.02
7.00	Total Medicare program liability (see instructions)		2,811,092		2,748,698	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1311 | Component CCN: 14-5552 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-1 Part I | Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		228,613		929	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		228,613		929	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		365	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		228,613		1,294	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1311	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part II Date/Time Prepared: 1/27/2022 1:36 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1311	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part V Date/Time Prepared: 1/27/2022 1:36 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,112,987	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,112,987	4.00
5.00	Primary payer payments	58	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,144,059	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,144,059	19.00
20.00	Deductibles (exclude professional component)	381,991	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,762,068	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,762,068	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	75,422	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	49,024	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	58,097	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,811,092	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,811,092	30.00
30.01	Sequestration adjustment (see instructions)	0	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,478,497	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	332,595	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1311 Component CCN: 14-5552	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VI Date/Time Prepared: 1/27/2022 1:36 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	247,668	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	247,668	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	19,055	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	228,613	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.98	Recovery of accelerated depreciation.	0	14.98
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	228,613	15.00
15.01	Sequestration adjustment (see instructions)	0	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	0	15.75
16.00	Interim payments	228,613	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

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

Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G | Date/Time Prepared: 1/27/2022 1:36 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	7,271,261	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	16,358,570	0	0	0	4.00
5.00	Other receivable	1,195,240	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,855,461	0	0	0	6.00
7.00	Inventory	649,434	0	0	0	7.00
8.00	Prepaid expenses	420,301	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	499,295	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	14,538,640	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	449,428	0	0	0	12.00
13.00	Land improvements	964,687	0	0	0	13.00
14.00	Accumulated depreciation	-661,229	0	0	0	14.00
15.00	Buildings	19,910,829	0	0	0	15.00
16.00	Accumulated depreciation	-15,692,871	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	2,186,470	0	0	0	19.00
20.00	Accumulated depreciation	-1,604,391	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	17,735,757	0	0	0	23.00
24.00	Accumulated depreciation	-11,270,821	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	18,609,356	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	30,627,215	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	3,227,302	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,227,302	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	48,393,157	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,010,319	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,802,816	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,210,858	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	340,055				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,364,048	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	521,406	0	0	0	46.00
47.00	Notes payable	15,932,497	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	16,453,903	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	24,817,951	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	23,575,206				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	23,575,206	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	48,393,157	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G-1 | Date/Time Prepared: 1/27/2022 1:36 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		16,895,719		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,679,487				2.00
3.00	Total (sum of line 1 and line 2)		23,575,206		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		23,575,206		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		23,575,206		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 1/27/2022 1:36 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,516,508		4,516,508	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,110,766		1,110,766	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,627,274		5,627,274	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	231,577		231,577	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	231,577		231,577	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,858,851		5,858,851	17.00
18.00	Ancillary services	10,096,204	68,304,904	78,401,108	18.00
19.00	Outpatient services	147,610	4,647,359	4,794,969	19.00
20.00	RURAL HEALTH CLINIC	0	5,343,960	5,343,960	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		548,822	548,822	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	345,584	5,675,403	6,020,987	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	16,448,249	84,520,448	100,968,697	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		36,983,641		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		36,983,641		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1311 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G-3 | Date/Time Prepared: 1/27/2022 1:36 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	100,968,697	1.00
2.00	Less contractual allowances and discounts on patients' accounts	64,803,269	2.00
3.00	Net patient revenues (line 1 minus line 2)	36,165,428	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	36,983,641	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-818,213	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	1,415,365	6.00
7.00	Income from investments	41,351	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	49,634	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	26,898	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	13,105	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	237,073	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER EXPENSES	326,377	24.00
24.50	COVID-19 PHE Funding	5,387,897	24.50
25.00	Total other income (sum of lines 6-24)	7,497,700	25.00
26.00	Total (line 5 plus line 25)	6,679,487	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,679,487	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1311 | HHA CCN: 14-7612 | Period: From 07/01/2020 To 06/30/2021 | Worksheet H | Date/Time Prepared: 1/27/2022 1:36 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	140,958	0	47,732	0	43,186	231,876	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	195,279	0	0	0	0	195,279	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	336,237	0	47,732	0	43,186	427,155	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	231,876	0	231,876			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	195,279	0	195,279			6.00
7.00	Physical Therapy	82,284	82,284	0	82,284			7.00
8.00	Occupational Therapy	26,881	26,881	0	26,881			8.00
9.00	Speech Pathology	2,539	2,539	0	2,539			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	0	0	0			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	111,704	538,859	0	538,859			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 14-1311 | HHA CCN: 14-7612 | Period: From 07/01/2020 To 06/30/2021 | Worksheet H-1 Part I | Date/Time Prepared: 1/27/2022 1:36 pm

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	231,876	0	0	0	0	231,876	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	195,279	0	0	0	0	195,279	6.00
7.00	Physical Therapy	82,284	0	0	0	0	82,284	7.00
8.00	Occupational Therapy	26,881	0	0	0	0	26,881	8.00
9.00	Speech Pathology	2,539	0	0	0	0	2,539	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	538,859	0	0	0	0	538,859	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	231,876			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	147,502	342,781		6.00
7.00	Physical Therapy	62,152	144,436		7.00
8.00	Occupational Therapy	20,304	47,185		8.00
9.00	Speech Pathology	1,918	4,457		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Home Health Aide	0	0		11.00
12.00	Supplies (see instructions)	0	0		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		538,859		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-1311 | HHA CCN: 14-7612 | Period: From 07/01/2020 To 06/30/2021 | Worksheet H-1 Part II Date/Time Prepared: 1/27/2022 1:36 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-231,876	306,983	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	195,279	6.00
7.00	Physical Therapy	0	0	0	0	0	82,284	7.00
8.00	Occupational Therapy	0	0	0	0	0	26,881	8.00
9.00	Speech Pathology	0	0	0	0	0	2,539	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-231,876	306,983	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		231,876	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.755338	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1311 | HHA CCN: 14-7612 | Period: From 07/01/2020 To 06/30/2021 | Worksheet H-2 Part I | Date/Time Prepared: 1/27/2022 1:36 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	22,959	9,662	41,676	74,297	14,828	1.00
2.00	Skilled Nursing Care	342,781	0	0	57,736	400,517	79,933	2.00
3.00	Physical Therapy	144,436	0	0	24,328	168,764	33,681	3.00
4.00	Occupational Therapy	47,185	0	0	7,948	55,133	11,003	4.00
5.00	Speech Pathology	4,457	0	0	751	5,208	1,039	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	538,859	22,959	9,662	132,439	703,919	140,484	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	22,247	18,735	0	23,009	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	22,247	18,735	0	23,009	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1311 HHA CCN: 14-7612

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

Worksheet H-2 Part I Date/Time Prepared: 1/27/2022 1:36 pm

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	Cost Center Description	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12.00	13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	0	36,663	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	36,663	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		19.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	189,779	0	189,779			1.00
2.00	Skilled Nursing Care	0	480,450	0	480,450	120,723	601,173	2.00
3.00	Physical Therapy	0	202,445	0	202,445	50,868	253,313	3.00
4.00	Occupational Therapy	0	66,136	0	66,136	16,618	82,754	4.00
5.00	Speech Pathology	0	6,247	0	6,247	1,570	7,817	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	945,057	0	945,057	189,779	945,057	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.251270		21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1311 HHA CCN: 14-7612

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

Worksheet H-2 Part II Date/Time Prepared: 1/27/2022 1:36 pm

Home Health Agency I

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	1,920	1,920	140,958	0	74,297	1,920	1.00
2.00	Skilled Nursing Care	0	0	195,279	0	400,517	0	2.00
3.00	Physical Therapy	0	0	82,284	0	168,764	0	3.00
4.00	Occupational Therapy	0	0	26,881	0	55,133	0	4.00
5.00	Speech Pathology	0	0	2,539	0	5,208	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,920	1,920	447,941		703,919	1,920	20.00
21.00	Total cost to be allocated	22,959	9,662	132,439		140,484	22,247	21.00
22.00	Unit cost multiplier	11.957812	5.032292	0.295662		0.199574	11.586979	22.00

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	
		7.00	8.00	9.00	10.00	11.00	12.00	
1.00	Administrative and General	1,920	0	1,920	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,920	0	1,920	0	0	0	20.00
21.00	Total cost to be allocated	18,735	0	23,009	0	0	0	21.00
22.00	Unit cost multiplier	9.757813	0.000000	11.983854	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1311
HHA CCN: 14-7612

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

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Part II
Date/Time Prepared:
1/27/2022 1:36 pm

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	Cost Center Description	NURSING ADMINISTRATION (DIRECT NRS ING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS.)	PHARMACY (COSTED REQ UIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (ASSIGNED TIME)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	17.00	19.00	
1.00	Administrative and General	13,235	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	13,235	0	0	0	0	0	20.00
21.00	Total cost to be allocated	36,663	0	0	0	0	0	21.00
22.00	Unit cost multiplier	2.770155	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-1311 HHA CCN: 14-7612 | Period: From 07/01/2020 To 06/30/2021 | Worksheet H-3 Part I Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	601,173		601,173	2,647	227.11	1.00
2.00	Physical Therapy	3.00	253,313	0	253,313	1,359	186.40	2.00
3.00	Occupational Therapy	4.00	82,754	0	82,754	504	164.19	3.00
4.00	Speech Pathology	5.00	7,817	0	7,817	56	139.59	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	0		0	0	0.00	6.00
7.00	Total (sum of lines 1-6)		945,057	0	945,057	4,566		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	1,665			8.00
9.00	Physical Therapy		99914	0	963			9.00
10.00	Occupational Therapy		99914	0	360			10.00
11.00	Speech Pathology		99914	0	39			11.00
12.00	Medical Social Services		99914	0	0			12.00
13.00	Home Health Aide		99914	0	0			13.00
14.00	Total (sum of lines 8-13)			0	3,027			14.00

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

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,665		0	378,138		1.00
2.00	Physical Therapy	0	963		0	179,503		2.00
3.00	Occupational Therapy	0	360		0	59,108		3.00
4.00	Speech Pathology	0	39		0	5,444		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	0		0	0		6.00
7.00	Total (sum of lines 1-6)	0	3,027		0	622,193		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1311 HHA CCN: 14-7612 | Period: From 07/01/2020 To 06/30/2021 | Worksheet H-3 Part I Date/Time Prepared: 1/27/2022 1:36 pm

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

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	72,222	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	378,138						1.00
2.00	Physical Therapy	179,503						2.00
3.00	Occupational Therapy	59,108						3.00
4.00	Speech Pathology	5,444						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	0						6.00
7.00	Total (sum of lines 1-6)	622,193						7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1311 | HHA CCN: 14-7612 | Period: From 07/01/2020 To 06/30/2021 | Worksheet H-3 Part II | Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.619530	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.588251	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.667499	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.106684	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.308963	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1311 | HHA CCN: 14-7612 | Period: From 07/01/2020 To 06/30/2021 | Worksheet H-4 Part I-II | Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	401,853	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	70,446	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	6,162	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	24,433	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	502,894	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	502,894	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	502,894	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	502,894	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	502,894	31.00
31.01	Sequestration adjustment (see instructions)	0	0	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	502,894	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 14-1311 | HHA CCN: 14-7612 | Period: From 07/01/2020 To 06/30/2021 | Worksheet H-5 | Date/Time Prepared: 1/27/2022 1:36 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		502,894	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		502,894	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		502,894	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1311 | Component CCN: 14-8500 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-1 | Date/Time Prepared: 1/27/2022 1:36 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,079,789	0	1,079,789	11,262	1,091,051	1.00
2.00	Physician Assistant	460,877	0	460,877	-1,105	459,772	2.00
3.00	Nurse Practitioner	419,698	0	419,698	6,268	425,966	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	229,853	0	229,853	2,798	232,651	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,190,217	0	2,190,217	19,223	2,209,440	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	157,056	157,056	0	157,056	15.00
16.00	Transportation (Health Care Staff)	0	11,166	11,166	0	11,166	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	168,222	168,222	0	168,222	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,190,217	168,222	2,358,439	19,223	2,377,662	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	20,095	20,095	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	20,095	20,095	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	41,377	41,377	0	41,377	29.00
30.00	Administrative Costs	1,343,339	358,661	1,702,000	3,650	1,705,650	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,343,339	400,038	1,743,377	3,650	1,747,027	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,533,556	568,260	4,101,816	42,968	4,144,784	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1311 | Component CCN: 14-8500 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-1 | Date/Time Prepared: 1/27/2022 1:36 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-56,129	1,034,922		1.00
2.00	Physician Assistant	0	459,772		2.00
3.00	Nurse Practitioner	-59,220	366,746		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	232,651		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-115,349	2,094,091		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	157,056		15.00
16.00	Transportation (Health Care Staff)	0	11,166		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	168,222		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-115,349	2,262,313		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	20,095		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	20,095		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	41,377		29.00
30.00	Administrative Costs	0	1,705,650		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	1,747,027		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-115,349	4,029,435		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1311 | Component CCN: 14-8500 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-2 | Date/Time Prepared: 1/27/2022 1:36 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.69	9,717	4,200	7,098		1.00
2.00	Physician Assistant	3.45	6,964	2,100	7,245		2.00
3.00	Nurse Practitioner	3.05	4,654	2,100	6,405		3.00
4.00	Subtotal (sum of lines 1 through 3)	8.19	21,335		20,748	21,335	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	3.13	2,986			2,986	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	11.32	24,321			24,321	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,262,313	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					20,095	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,282,408	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.991196	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,747,027	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,772,068	15.00
16.00	Total overhead (sum of lines 14 and 15)					5,519,095	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					5,519,095	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					5,470,505	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					7,732,818	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1311 Component CCN: 14-8500	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 1/27/2022 1:36 pm
	Title XVIII	RHC I	Cost

					1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)				7,732,818	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)				112,962	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)				7,619,856	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)				24,321	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)				0	5.00
6.00	Total adjusted visits (line 4 plus line 5)				24,321	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)				313.30	7.00
		Calculation of Limit (1)				
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)		
		1.00	2.00	3.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	268.45		8.00
9.00	Rate for Program covered visits (see instructions)	313.30	313.30	268.45		9.00
	CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	3,711	1,607	1,776		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	1,162,656	503,473	476,767		11.00
12.00	Program covered visits for mental health services (from contractor records)	135	66	47		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	42,296	20,678	12,617		13.00
14.00	Limit adjustment for mental health services (see instructions)	42,296	20,678	12,617		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	2,218,487			16.00
16.01	Total program charges (see instructions)(from contractor's records)		969,835			16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		155,447			16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		355,584			16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,403,330			16.04
16.05	Total program cost (see instructions)	0	1,758,914			16.05
17.00	Primary payer amounts		0			17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		108,741			18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		141,118			19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,758,914			20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		70,804			21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,829,718			22.00
23.00	Allowable bad debts (see instructions)		42,908			23.00
23.01	Adjusted reimbursable bad debts (see instructions)		27,890			23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		28,934			24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0			25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0			25.50
25.99	Demonstration payment adjustment amount before sequestration		0			25.99
26.00	Net reimbursable amount (see instructions)		1,857,608			26.00
26.01	Sequestration adjustment (see instructions)		0			26.01
26.02	Demonstration payment adjustment amount after sequestration		0			26.02
27.00	Interim payments		1,453,051			27.00
28.00	Tentative settlement (for contractor use only)		0			28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		404,557			29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0			30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1311 | Component CCN: 14-8500 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-4 | Date/Time Prepared: 1/27/2022 1:36 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,094,091	2,094,091	2,094,091	2,094,091	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000237	0.000940	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	496	1,968	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	16,377	14,208	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	16,873	16,176	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,262,313	2,262,313	2,262,313	2,262,313	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	5,470,505	5,470,505	5,470,505	5,470,505	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.007458	0.007150	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	40,799	39,114	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	57,672	55,290	0	0	10.00
11.00	Total number of injections/infusions (from your records)	121	479	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	476.63	115.43	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	96	217	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	45,756	25,048	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		112,962			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		70,804			16.00

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

Provider CCN: 14-1311 | Component CCN: 14-8500 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-5 | Date/Time Prepared: 1/27/2022 1:36 pm

RHC I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		967,751	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		04/29/2021	485,300	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		485,300	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,453,051	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		404,557	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,857,608	7.00

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