

State Copy

Health Financial Systems

GRAHAM HOSPITAL ASSOCIATION

In Lieu of Form CMS-2552-10

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/23/2021 8:29 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report	Date:	Time:
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ 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. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GRAHAM HOSPITAL ASSOCIATION (14-0001) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	506,954	139,210	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	10,458	27		0	7.00
8.00	NURSING FACILITY	0				0	8.00
10.00	RURAL HEALTH CLINIC I	0		484,209		0	10.00
10.01	ELMWOOD RHC II	0		9,628		0	10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	517,412	633,074	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-0001		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 8:29 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 210 WEST WALNUT		PO Box:						1.00		
2.00	City: CANTON		State: IL		Zip Code: 61520-		County: FULTON		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		GRAHAM HOSPITAL ASSOCIATION	140001	99914	1	07/19/1966	N	P	N	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		GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N	P	N	9.00
10.00	Hospital-Based NF		GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N		O	10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC		GRAHAM MEDICAL GROUP - LEWISTOWN	143493	99914		01/01/2008	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II		GRAHAM MEDICAL GROUP - ELMWOOD	148603	99914		10/23/2019	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020	06/30/2021		20.00	
21.00	Type of Control (see instructions)						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.					Y	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N	22.03	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									22.04	
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: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/23/2021 8:29 am

		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.	1,334	0	0	0	152	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.					1		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.					07/01/2020	06/30/2021	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	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
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
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
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
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		
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.							
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		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0001		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 8:29 am	
		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 adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		20.00	1		60.01	
		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)				0.00	0.00	
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	
61.20	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	
						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	
62.01	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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/23/2021 8:29 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0001		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 8:29 am	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				1.00		2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
		1.00		2.00		3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	0		0		1,624,563118.01	
				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.	Y		5.00		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: 14-0001		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 8:29 am	
		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)	N				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	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						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	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						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	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			9.99		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 8:29 am
			Beginning 1.00	Ending 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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/23/2021 8:29 am	
			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	09/22/2021	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.	Y			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	Y	Y		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
			Part A		Part B
			Y/N	Date	Y/N
			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)	N		N	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)	Y	10/20/2021	Y	10/20/2021
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: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/23/2021 8:29 am

		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.		N		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.		N		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.	DAVID	GOODMAN		41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	608.270.2962	DGOODMAN@WIPFLI.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/23/2021 8:29 am
		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.	CPA		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

Health Financial Systems		GRAHAM HOSPITAL ASSOCIATION		Non-CMS HFS Worksheet	
HFS Supplemental Information		Provider CCN: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part IX Date/Time Prepared: 11/23/2021 8:29 am	
			Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	Y	Y	1.00	
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	Y	2.00	
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	Y	3.00	
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01	
3.02	Does Title XIX transfer managed care (HMO) days from Worksheet S-3, Part I, column 7, sum of lines 2, 3, and 4 to Worksheet E-4, column 2, line 26?		Y	3.02	
			Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00	
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00	
			Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	Y	Y	6.00	
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y	7.00	
RHC					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00	
FQHC					
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00	
			State 1.00		
STATE MEDICAID FORMS					
10.00	Select the state when using state Medicaid forms.				10.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/23/2021 8:29 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					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	38	13,870	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		38	13,870	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	5	1,825	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		43	15,695	0.00	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	20	7,300		0	19.00
20.00 NURSING FACILITY	45.00	18	6,570		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						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
26.01 ELMWOOD RHC	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		81				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: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/23/2021 8:29 am

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)	2,973	869	5,635		1.00
2.00	HMO and other (see instructions)	1,267	152			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)	2,973	869	5,635		7.00
8.00	INTENSIVE CARE UNIT	490	231	1,115		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		234	376		13.00
14.00	Total (see instructions)	3,463	1,334	7,126	0.00	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	1,036	23	1,463	0.00	19.00
20.00	NURSING FACILITY		1,924	3,332	0.00	20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					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)	16,390	25,035	80,828	0.00	26.00
26.01	ELMWOOD RHC	0	0	4,226	0.00	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	561.04
28.00	Observation Bed Days		0	1,481		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)			108		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: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/23/2021 8:29 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	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	801	348	1,855	1.00
2.00 HMO and other (see instructions)			345	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	801	348	1,855	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	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						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
26.01 ELMWOOD RHC	0.00					26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/23/2021 8:29 am

	Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	37,092,591	0	37,092,591	1,166,953.50	31.79 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		1,671,326	0	1,671,326	12,480.00	133.92 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non Physician-Part B		3,888,490	-24,349	3,864,141	26,668.22	144.90 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		3,996,126	0	3,996,126	153,545.60	26.03 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	906,928	0	906,928	48,422.40	18.73 9.00
10.00	Excluded area salaries (see instructions)		1,534,860	129,979	1,664,839	46,281.03	35.97 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		498,159	0	498,159	6,759.07	73.70 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		0	0	0	0.00	0.00 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00 16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,763,395	0	4,763,395		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		534,244	0	534,244		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		581,745	0	581,745		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		1,345,006	0	1,345,006		
24.00	Wage-related costs (RHC/FQHC)		1,885,384	0	1,885,384		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
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		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	85,018	0	85,018	7,217.60	11.78	26.00
27.00	Administrative & General	5.00	8,370,922	0	8,370,922	278,220.80	30.09	27.00
28.00	Administrative & General under contract (see inst.)		975,402	0	975,402	11,789.15	82.74	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	838,986	-21	838,965	42,297.50	19.83	30.00
31.00	Laundry & Linen Service	8.00	32,579	0	32,579	2,620.80	12.43	31.00
32.00	Housekeeping	9.00	855,098	0	855,098	56,659.20	15.09	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	710,097	-614,859	95,238	5,615.99	16.96	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	614,859	614,859	36,254.41	16.96	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	651,680	0	651,680	16,390.40	39.76	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	753,886	0	753,886	22,692.80	33.22	40.00
41.00	Medical Records & Medical Records Library	16.00	411,369	0	411,369	20,448.00	20.12	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part III
Date/Time Prepared:
11/23/2021 8:29 am

	Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	28,512,051	24,349	28,536,400	986,048.83	28.94	1.00
2.00	Excluded area salaries (see instructions)	2,441,788	129,979	2,571,767	94,703.43	27.16	2.00
3.00	Subtotal salaries (line 1 minus line 2)	26,070,263	-105,630	25,964,633	891,345.40	29.13	3.00
4.00	Subtotal other wages & related costs (see inst.)	498,159	0	498,159	6,759.07	73.70	4.00
5.00	Subtotal wage-related costs (see inst.)	4,763,395	0	4,763,395	0.00	18.35	5.00
6.00	Total (sum of lines 3 thru 5)	31,331,817	-105,630	31,226,187	898,104.47	34.77	6.00
7.00	Total overhead cost (see instructions)	13,685,037	-21	13,685,016	500,206.65	27.36	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 11/23/2021 8:29 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		849,382	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		4,000	6.00
7.00	Employee Managed Care Program Administration Fees		238,469	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		6,147,755	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		16,955	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		126,422	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		339,381	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		2,474,575	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		-67,148	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		326,238	21.00
22.00	Day Care Cost and Allowances		16,264	22.00
23.00	Tuition Reimbursement		81,300	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		10,553,593	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part V
Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	527,132	10,553,591	1.00
2.00	Hospital	511,959	10,553,591	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	15,173	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0001 Component CCN: 14-3493		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 11/23/2021 8:29 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				180 S MAIN STREET				1.00
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				CANTON		IL 61520		2.00
								1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
								1.00	
								2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
11.00	Facility hours of operations (1)								
CLINIC	08:30		15:00		07:30		17:30		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		3		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number				FARMINGTON CLINIC		143494		14.00
14.01					CANTON CLINIC		143492		14.01
14.02					LEWISTOWN CLINIC		143493		14.02
				Y/N		V		XVIII	
				1.00		2.00		3.00	
								XIX	
								Total Visits	
								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				FULTON				2.00
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC		17:30		07:30		17:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN:14-0001 Component CCN:14-3493		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 11/23/2021 8:29 am	
						RHC I		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC			07:30	17:30	08:30	17:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0001 Component CCN: 14-8603		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 11/23/2021 8:29 am		
				RHC II		Cost				
				1.00						
Clinic Address and Identification										
1.00	Street				1024 N MAGNOLIA STREET			1.00		
				City		State		ZIP Code		
				1.00		2.00		3.00		
2.00	City, State, ZIP Code, County				ELMWOOD IL 61529			2.00		
				1.00						
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00	
				Grant Award		Date				
				1.00		2.00				
Source of Federal Funds										
4.00	Community Health Center (Section 330(d), PHS Act)							4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00		
7.00	Appalachian Regional Commission							7.00		
8.00	Look-Alikes							8.00		
9.00	OTHER (SPECIFY)							9.00		
				1.00		2.00				
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00	
				Sunday		Monday		Tuesday		
				from to		from to		from		
				1.00 2.00		3.00 4.00		5.00		
Facility hours of operations (1)										
11.00	CLINIC				08:00		17:30		08:00	
				1.00		2.00				
12.00	Have you received an approval for an exception to the productivity standard?				N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00	
				Provider name		CCN number				
				1.00		2.00				
14.00	RHC/FQHC name, CCN number								14.00	
				Y/N		V		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				PEORIA				2.00	
				Tuesday		Wednesday		Thursday		
				to		from to		from to		
				6.00		7.00 8.00		9.00 10.00		
Facility hours of operations (1)										
11.00	CLINIC				17:30		08:00		17:30	
				08:00		17:30		08:00		
				17:30		08:00		17:30		

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0001 Component CCN: 14-8603		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 11/23/2021 8:29 am	
						RHC II		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC	08:00	17:30						11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/23/2021 8:29 am
				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)			0.368075
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			8,205,221
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			2,261,458
6.00	Medicaid charges			51,373,277
7.00	Medicaid cost (line 1 times line 6)			18,909,219
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)			8,442,540
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP			0
10.00	Stand-alone CHIP charges			0
11.00	Stand-alone CHIP cost (line 1 times line 10)			0
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0
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
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0
15.00	State or local indigent care program cost (line 1 times line 14)			0
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
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
18.00	Government grants, appropriations or transfers for support of hospital operations			0
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			8,442,540
		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)	509,028	2,802,905	3,311,933
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	187,360	2,802,905	2,990,265
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	187,360	2,802,905	2,990,265
				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
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0
26.00	Total bad debt expense for the entire hospital complex (see instructions)			6,851,148
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			406,622
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			625,572
28.00	Non-Medicare bad debt expense (see instructions)			6,225,576
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			2,510,429
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			5,500,694
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			13,943,234

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0001

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

Worksheet A

Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		6,795,022	6,795,022	-2,827,991	3,967,031	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,855,555	2,855,555	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	85,018	10,902,378	10,987,396	-107,193	10,880,203	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,370,922	13,305,867	21,676,789	-4,255,581	17,421,208	5.00
7.00	00700	OPERATION OF PLANT	838,986	1,892,477	2,731,463	-21	2,731,442	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	32,579	147,114	179,693	116,019	295,712	8.00
9.00	00900	HOUSEKEEPING	855,098	122,455	977,553	16,207	993,760	9.00
10.00	01000	DIETARY	710,097	481,100	1,191,197	-868,989	322,208	10.00
11.00	01100	CAFETERIA	0	0	0	868,989	868,989	11.00
13.00	01300	NURSING ADMINISTRATION	651,680	59,385	711,065	0	711,065	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	753,886	1,885,557	2,639,443	0	2,639,443	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	411,369	253,410	664,779	0	664,779	16.00
20.00	02000	NURSING SCHOOL	1,228,605	317,976	1,546,581	0	1,546,581	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,376,482	539,393	3,915,875	59,207	3,975,082	30.00
31.00	03100	INTENSIVE CARE UNIT	778,845	79,308	858,153	-7,416	850,737	31.00
43.00	04300	NURSERY	0	0	0	8,565	8,565	43.00
44.00	04400	SKILLED NURSING FACILITY	906,928	56,265	963,193	0	963,193	44.00
45.00	04500	NURSING FACILITY	247,203	2,925	250,128	0	250,128	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,610,126	3,835,789	5,445,915	-2,451,269	2,994,646	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0	0	17,572	17,572	52.01
53.00	05300	ANESTHESIOLOGY	1,671,326	82,546	1,753,872	0	1,753,872	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	859,062	995,814	1,854,876	-2,220	1,852,656	54.00
57.00	05700	CT SCAN	80,229	222,625	302,854	0	302,854	57.00
58.00	05800	MRI	69,411	122,994	192,405	0	192,405	58.00
60.00	06000	LABORATORY	1,620,951	1,946,451	3,567,402	2,742,117	6,309,519	60.00
65.00	06500	RESPIRATORY THERAPY	688,070	78,458	766,528	26,400	792,928	65.00
66.00	06600	PHYSICAL THERAPY	1,146,022	294,004	1,440,026	0	1,440,026	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	799,352	799,352	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,707,013	1,707,013	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,306,435	2,306,435	310,960	2,617,395	73.00
76.97	07697	CARDIAC REHABILITATION	128,027	71,158	199,185	19,338	218,523	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,474,269	9,655,651	15,129,920	-3,859	15,126,061	88.00
88.01	08801	ELMWOOD RHC	0	0	0	723,857	723,857	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	554,957	723,687	1,278,644	15,370	1,294,014	90.01
91.00	09100	EMERGENCY	3,438,177	290,905	3,729,082	60,413	3,789,495	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	445,214	819,754	1,264,968	15,970	1,280,938	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,033,539	58,286,903	95,320,442	-161,635	95,158,807	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	1,338	1,338	21	1,359	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	5,702	5,702	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	59,052	15,332	74,384	0	74,384	194.11
194.12	07962	AVON CLINIC	0	0	0	75,874	75,874	194.12
194.13	07963	WILLIAMSFIELD CLINIC	0	0	0	80,038	80,038	194.13
200.00		TOTAL (SUM OF LINES 118 through 199)	37,092,591	58,303,573	95,396,164	0	95,396,164	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0001

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

Worksheet A

Date/Time Prepared:
11/23/2021 8:29 am

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	-828,712	3,138,319	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-3,828	2,851,727	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-802,839	10,077,364	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,453,755	13,967,453	5.00
7.00	00700	OPERATION OF PLANT	0	2,731,442	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	295,712	8.00
9.00	00900	HOUSEKEEPING	-272	993,488	9.00
10.00	01000	DIETARY	-314,378	7,830	10.00
11.00	01100	CAFETERIA	-203,285	665,704	11.00
13.00	01300	NURSING ADMINISTRATION	-1,518	709,547	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-1,891,861	747,582	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-14,569	650,210	16.00
20.00	02000	NURSING SCHOOL	-301,346	1,245,235	20.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-152,458	3,822,624	30.00
31.00	03100	INTENSIVE CARE UNIT	0	850,737	31.00
43.00	04300	NURSERY	0	8,565	43.00
44.00	04400	SKILLED NURSING FACILITY	-816	962,377	44.00
45.00	04500	NURSING FACILITY	0	250,128	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,994,646	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	17,572	52.01
53.00	05300	ANESTHESIOLOGY	-1,671,326	82,546	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,852,656	54.00
57.00	05700	CT SCAN	0	302,854	57.00
58.00	05800	MRI	0	192,405	58.00
60.00	06000	LABORATORY	-65,851	6,243,668	60.00
65.00	06500	RESPIRATORY THERAPY	0	792,928	65.00
66.00	06600	PHYSICAL THERAPY	0	1,440,026	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	799,352	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,707,013	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,617,395	73.00
76.97	07697	CARDIAC REHABILITATION	-36,322	182,201	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-10,453	15,115,608	88.00
88.01	08801	ELMWOOD RHC	0	723,857	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CLINIC	-294,301	999,713	90.01
91.00	09100	EMERGENCY	-1,871,488	1,918,007	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-26,375	1,254,563	96.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,945,753	83,213,054	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	1,359	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
193.02	19302	FOUNDATION	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	194.01
194.02	07952	FRESENIUS	0	0	194.02
194.03	07953	RUCHFORD POB	0	5,702	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	194.05
194.06	07956	LEWISTON POB	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	194.07
194.08	07958	KELLEY HOME	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	194.10
194.11	07961	WELLNESS CENTER	0	74,384	194.11
194.12	07962	AVON CLINIC	0	75,874	194.12
194.13	07963	WILLIAMSFIELD CLINIC	0	80,038	194.13
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,945,753	83,450,411	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0001

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

Worksheet Non-CMS W

Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
20.00	NURSING SCHOOL	02000		20.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
45.00	NURSING FACILITY	04500		45.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
52.01	DELIVERY ROOM & LABOR ROOM	05201		52.01
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
57.00	CT SCAN	05700		57.00
58.00	MRI	05800		58.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	08800		88.00
88.01	ELMWOOD RHC	08801		88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90.00	CLINIC	09000		90.00
90.01	WOUND CLINIC	09001		90.01
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	DURABLE MEDICAL EQUIP-RENTED	09600		96.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT FLOWER COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS PRIVATE OFFICES	19200		192.00
192.01	CANTON RHC RENTED SPACE	19201		192.01
193.00	NONPAID WORKERS	19300		193.00
193.02	FOUNDATION	19302		193.02
194.00	PHYSICIANS CLINIC	07950		194.00
194.01	PROCTOR CHEMICAL DEPENDENCY	07951		194.01
194.02	FRESENIUS	07952		194.02
194.03	RUCHFORD POB	07953		194.03
194.04	EP COLEMAN RENTAL SPACE	07954		194.04
194.05	FARMINGTON POB	07955		194.05
194.06	LEWISTON POB	07956		194.06
194.07	OTHER RENTAL PROPERTY	07957		194.07
194.08	KELLEY HOME	07958		194.08
194.09	EMPLOYEE PURCHASE	07959		194.09
194.10	RETAIL PHARMACY	07960		194.10
194.11	WELLNESS CENTER	07961		194.11
194.12	AVON CLINIC	07962		194.12
194.13	WILLIAMSFIELD CLINIC	07963		194.13
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0001

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

Worksheet A-6

Date/Time Prepared:
11/23/2021 8:29 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	614,859	254,130		1.00
	TOTALS		614,859	254,130		
	B - MAINTENANCE LABOR RECLASS					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	21	0		1.00
	TOTALS		21	0		
	C - OFFSITE CAPITAL RECLASS					
1.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	15,970		1.00
2.00	ELMWOOD RHC	88.01	0	59,699		2.00
3.00	RUCHFORD POB	194.03	0	4,304		3.00
	TOTALS		0	79,973		
	D - PROPERTY INSURANCE RECLASS					
1.00	OTHER CAP REL COSTS	3.00	0	126,875		1.00
2.00	RUCHFORD POB	194.03	0	1,398		2.00
	TOTALS		0	128,273		
	E - DEPRECIATION RECLASS					
1.00	CARDIAC REHABILITATION	76.97	0	19,338		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,822,632		2.00
	TOTALS		0	2,841,970		
	F - RHC EXPENSE RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	95,394	0		1.00
2.00	ELMWOOD RHC	88.01	200,588	463,570		2.00
3.00	AVON CLINIC	194.12	59,721	16,153		3.00
4.00	WILLIAMSFIELD CLINIC	194.13	70,237	9,801		4.00
	TOTALS		425,940	489,524		
	G - EMPLOYEE BENEFIT AUDIT RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,000		1.00
	TOTALS		0	4,000		
	H - IMPLANT RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,707,013		1.00
	TOTALS		0	1,707,013		
	I - MED SUP CHARGE TO PATIENTS RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	799,352		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	TOTALS		0	799,352		
	J - RECLASS PHYSICIAN BENEFITS					
1.00	EMERGENCY	91.00	0	71,540		1.00
2.00	WOUND CLINIC	90.01	0	39,653		2.00
	TOTALS		0	111,193		
	K - RECLASS OB SALARIES					
1.00	NURSERY	43.00	8,565	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.01	17,572	0		2.00
	TOTALS		26,137	0		
	L - RECLASS DEPT COVID EXPENSES					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	116,019		1.00
2.00	HOUSEKEEPING	9.00	0	16,207		2.00
3.00	LABORATORY	60.00	0	2,742,117		3.00
4.00	RESPIRATORY THERAPY	65.00	0	26,400		4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	310,960		5.00
6.00	RURAL HEALTH CLINIC	88.00	0	911,605		6.00
	TOTALS		0	4,123,308		
500.00	Grand Total: Increases		1,066,957	10,538,736		500.00

RECLASSIFICATIONS

Provider CCN: 14-0001

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

Worksheet A-6

Date/Time Prepared:
11/23/2021 8:29 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - CAFETERIA RECLASS						1.00
	DIETARY	10.00	614,859	254,130	0		
	TOTALS		614,859	254,130			
1.00	B - MAINTENANCE LABOR RECLASS						1.00
	OPERATION OF PLANT	7.00	21	0	0		
	TOTALS		21	0			
1.00 2.00 3.00	C - OFFSITE CAPITAL RECLASS						1.00 2.00 3.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	79,973	9		
		0.00	0	0	0		
		0.00	0	0	0		
	TOTALS		0	79,973			
1.00 2.00	D - PROPERTY INSURANCE RECLASS						1.00 2.00
	ADMINISTRATIVE & GENERAL	5.00	0	128,273	12		
		0.00	0	0	0		
	TOTALS		0	128,273			
1.00 2.00	E - DEPRECIATION RECLASS						1.00 2.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	2,841,970	9		
		0.00	0	0	9		
	TOTALS		0	2,841,970			
1.00 2.00 3.00 4.00	F - RHC EXPENSE RECLASS						1.00 2.00 3.00 4.00
	RURAL HEALTH CLINIC	88.00	425,940	489,524	0		
		0.00	0	0	0		
		0.00	0	0	0		
		0.00	0	0	0		
	TOTALS		425,940	489,524			
1.00	G - EMPLOYEE BENEFIT AUDIT RECLASS						1.00
	ADMINISTRATIVE & GENERAL	5.00	0	4,000	0		
	TOTALS		0	4,000			
1.00	H - IMPLANT RECLASS						1.00
	OPERATING ROOM	50.00	0	1,707,013	0		
	TOTALS		0	1,707,013			
1.00 2.00 3.00 4.00 5.00 6.00	I - MED SUP CHARGE TO PATIENTS RECLASS						1.00 2.00 3.00 4.00 5.00 6.00
	ADULTS & PEDIATRICS	30.00	0	10,050	0		
	INTENSIVE CARE UNIT	31.00	0	7,416	0		
	OPERATING ROOM	50.00	0	744,256	0		
	RADIOLOGY-DIAGNOSTIC	54.00	0	2,220	0		
	WOUND CLINIC	90.01	0	24,283	0		
	EMERGENCY	91.00	0	11,127	0		
	TOTALS		0	799,352			
1.00 2.00	J - RECLASS PHYSICIAN BENEFITS						1.00 2.00
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	111,193	0		
		0.00	0	0	0		
	TOTALS		0	111,193			
1.00 2.00	K - RECLASS OB SALARIES						1.00 2.00
	ADULTS & PEDIATRICS	30.00	26,137	0	0		
		0.00	0	0	0		
	TOTALS		26,137	0			
1.00 2.00 3.00 4.00 5.00 6.00	L - RECLASS DEPT COVID EXPENSES						1.00 2.00 3.00 4.00 5.00 6.00
	ADMINISTRATIVE & GENERAL	5.00	0	4,123,308	0		
		0.00	0	0	0		
		0.00	0	0	0		
		0.00	0	0	0		
		0.00	0	0	0		
		0.00	0	0	0		
	TOTALS		0	4,123,308			
500.00	Grand Total: Decreases			1,066,957	10,538,736		500.00

RECLASSIFICATIONS

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
11/23/2021 8:29 am

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
A - CAFETERIA RECLASS									
1.00	CAFETERIA	11.00	614,859	254,130	DIETARY	10.00	614,859	254,130	1.00
	TOTALS		614,859	254,130	TOTALS		614,859	254,130	
B - MAINTENANCE LABOR RECLASS									
1.00	PHYSICIANS PRIVATE OFFICES	192.00	21	0	OPERATION OF PLANT	7.00	21	0	1.00
	TOTALS		21	0	TOTALS		21	0	
C - OFFSITE CAPITAL RECLASS									
1.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	15,970	CAP REL COSTS-BLDG & FIXT	1.00	0	79,973	1.00
2.00	ELMWOOD RHC	88.01	0	59,699		0.00	0	0	2.00
3.00	RUCHFORD POB	194.03	0	4,304		0.00	0	0	3.00
	TOTALS		0	79,973	TOTALS		0	79,973	
D - PROPERTY INSURANCE RECLASS									
1.00	OTHER CAP REL COSTS	3.00	0	126,875	ADMINISTRATIVE & GENERAL	5.00	0	128,273	1.00
2.00	RUCHFORD POB	194.03	0	1,398		0.00	0	0	2.00
	TOTALS		0	128,273	TOTALS		0	128,273	
E - DEPRECIATION RECLASS									
1.00	CARDIAC REHABILITATION	76.97	0	19,338	CAP REL COSTS-BLDG & FIXT	1.00	0	2,841,970	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,822,632		0.00	0	0	2.00
	TOTALS		0	2,841,970	TOTALS		0	2,841,970	
F - RHC EXPENSE RECLASS									
1.00	ADULTS & PEDIATRICS	30.00	95,394	0	RURAL HEALTH CLINIC	88.00	425,940	489,524	1.00
2.00	ELMWOOD RHC	88.01	200,588	463,570		0.00	0	0	2.00
3.00	AVON CLINIC	194.12	59,721	16,153		0.00	0	0	3.00
4.00	WILLIAMSFIELD CLINIC	194.13	70,237	9,801		0.00	0	0	4.00
	TOTALS		425,940	489,524	TOTALS		425,940	489,524	
G - EMPLOYEE BENEFIT AUDIT RECLASS									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,000	ADMINISTRATIVE & GENERAL	5.00	0	4,000	1.00
	TOTALS		0	4,000	TOTALS		0	4,000	
H - IMPLANT RECLASS									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,707,013	OPERATING ROOM	50.00	0	1,707,013	1.00
	TOTALS		0	1,707,013	TOTALS		0	1,707,013	
I - MED SUP CHARGE TO PATIENTS RECLASS									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	799,352	ADULTS & PEDIATRICS	30.00	0	10,050	1.00
2.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	7,416	2.00
3.00		0.00	0	0	OPERATING ROOM	50.00	0	744,256	3.00
4.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	2,220	4.00
5.00		0.00	0	0	WOUND CLINIC	90.01	0	24,283	5.00
6.00		0.00	0	0	EMERGENCY	91.00	0	11,127	6.00
	TOTALS		0	799,352	TOTALS		0	799,352	
J - RECLASS PHYSICIAN BENEFITS									
1.00	EMERGENCY	91.00	0	71,540	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	111,193	1.00
2.00	WOUND CLINIC	90.01	0	39,653		0.00	0	0	2.00
	TOTALS		0	111,193	TOTALS		0	111,193	
K - RECLASS OB SALARIES									
1.00	NURSERY	43.00	8,565	0	ADULTS & PEDIATRICS	30.00	26,137	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.01	17,572	0		0.00	0	0	2.00
	TOTALS		26,137	0	TOTALS		26,137	0	
L - RECLASS DEPT COVID EXPENSES									
1.00	LAUNDRY & LINEN SERVICE	8.00	0	116,019	ADMINISTRATIVE & GENERAL	5.00	0	4,123,308	1.00
2.00	HOUSEKEEPING	9.00	0	16,207		0.00	0	0	2.00
3.00	LABORATORY	60.00	0	2,742,117		0.00	0	0	3.00
4.00	RESPIRATORY THERAPY	65.00	0	26,400		0.00	0	0	4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	310,960		0.00	0	0	5.00
6.00	RURAL HEALTH CLINIC	88.00	0	911,605		0.00	0	0	6.00
	TOTALS		0	4,123,308	TOTALS		0	4,123,308	
500.00	Grand Total: Increases		1,066,957	10,538,736	Grand Total: Decreases		1,066,957	10,538,736	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/23/2021 8:29 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,872,211	379,458	0	379,458	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	87,870,328	228,313	0	228,313	215,159	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	11,489,571	594,348	0	594,348	1,021,821	5.00
6.00	Movable Equipment	36,946,836	2,345,858	0	2,345,858	2,428,400	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	142,178,946	3,547,977	0	3,547,977	3,665,380	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	142,178,946	3,547,977	0	3,547,977	3,665,380	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,251,669	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	87,883,482	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	11,062,098	0				5.00
6.00	Movable Equipment	36,864,294	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	142,061,543	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	142,061,543	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/23/2021 8:29 am

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	6,795,022	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,795,022	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	6,795,022				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	6,795,022				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	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	105,197,248	0	105,197,248	0.740505	93,952	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	36,864,294	0	36,864,294	0.259495	32,923	2.00
3.00	Total (sum of lines 1-2)	142,061,542	0	142,061,542	1.000000	126,875	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	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	93,952	3,873,079	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	32,923	2,818,804	0	2.00
3.00	Total (sum of lines 1-2)	0	0	126,875	6,691,883	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	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	-828,712	93,952	0	0	3,138,319	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	32,923	0	0	2,851,727	2.00
3.00	Total (sum of lines 1-2)	-828,712	126,875	0	0	5,990,046	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0001

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

Worksheet A-8

Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-160,885	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-36,570	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-10,483	ADMINISTRATIVE & GENERAL	5.00	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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-3,821	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,398,075			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	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	-203,285	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	-14,569	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	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0001

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

Worksheet A-8

Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	DIETARY VENDOR REBATES/REFUNDS	B	-5,285	DIETARY	10.00	0	33.00
33.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.02
33.03	MEDICAL STAFF DUES	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OTHER INCOME & PURCHASE GROUP	B	-125,273	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	HOUSKEEPING OTHER REVENUE	B	-272	HOUSEKEEPING	9.00	0	33.05
33.06	DIETARY CONSULTANT AND EMP PURCHASE	B	-309,093	DIETARY	10.00	0	33.06
33.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.07
33.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.08
33.09	NRSNG SVS CPR CLASS FEES	B	-1,518	NURSING ADMINISTRATION	13.00	0	33.09
33.10	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-119,293	PHARMACY	15.00	0	33.10
33.11	REFUND/EXP REBATE	B	-223	PHARMACY	15.00	0	33.11
33.12	CARDIAC OTHER REVENUE	B	-18,622	CARDIAC REHABILITATION	76.97	0	33.12
33.15	RHC OTHER INCOME	B	-10,453	RURAL HEALTH CLINIC	88.00	0	33.15
33.16	HME NON PATIENT SALES	B	-11,098	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.16
33.17	HME HME OTHER REVENUE	B	-9,566	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.17
33.18	LAB OTHER REVENUE	B	0	LABORATORY	60.00	0	33.18
33.20	NURSG SCHOOL(TUITN FEES BOOKS ETC.)	B	-301,346	NURSING SCHOOL	20.00	0	33.20
33.21	DONATIONS & DUES	A	-16,900	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.22
33.23	CRNA SALARIES EXPENSE	A	-1,671,326	ANESTHESIOLOGY	53.00	0	33.23
33.26	CRNA BENEFITS EXPENSE	A	-382,767	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.26
33.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.27
33.28	LAB REFUND/REBATES	B	-3,723	LABORATORY	60.00	0	33.28
33.29	IL HOSPITAL PROVIDER TAX	A	-2,562,886	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.30
33.31	PHONE SALARIES EXPENSE	A	-3,062	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	PHONE BENEFIT EXPENSE	A	-701	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.32
33.33	PHONE OTHER EXPENSE	A	-1,621	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	PHONE DEPREPATION M/M EXPENSE	A	-7	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.34
33.35	IHA & AHA DUES LOBBYING PORTION	A	-22,680	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	IL HEALTHCARE ASSOCIATION LOBBYING	A	-816	SKILLED NURSING FACILITY	44.00	0	33.36
33.38	MARKETING DEPT SALARY EXPENSE	A	-98,070	ADMINISTRATIVE & GENERAL	5.00	0	33.38
33.39	MARKETING DEPT BENEFIFT EXPENSE	A	-22,460	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.39
33.40	MARKETING DEPT OTHER EXPENSE	A	-168,201	ADMINISTRATIVE & GENERAL	5.00	0	33.40
33.41	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.41
33.43	PHYSICIAN RECRUITMENT	A	-408,009	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.44	LOAN FORGIVENESS EXPENSE	A	-396,911	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44
33.45	RETAIL PHARMACY EXPENSES	A	-1,772,345	PHARMACY	15.00	0	33.45
33.46	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.46
33.47	SWAP INTEREST RATE EXPENSE	A	-667,827	CAP REL COSTS-BLDG & FIXT	1.00	11	33.47
33.49	GRI HME EMPLOYEE & GUEST REVENUE	B	-5,711	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.49
33.50	EMERGENCY ROOM OTHER INCOME	B	0	EMERGENCY	91.00	0	33.50
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,945,753				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.

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0001

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

Worksheet A-8

Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		11/20/2021 3:10 am	
			Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0001

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

Worksheet A-8-2

Date/Time Prepared:
11/23/2021 8:29 am

	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	91.00	EMERGENCY	1,876,185	1,849,298	26,887	171,400	57	1.00
2.00	90.01	WOUND CLINIC	302,212	290,212	12,000	171,400	96	2.00
3.00	76.97	CARDIAC REHABILITATION	17,700	17,700	0	0	0	3.00
4.00	60.00	LABORATORY	57,000	0	57,000	171,400	500	4.00
5.00	60.00	LABORATORY	46,330	46,330	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	152,458	152,458	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			2,451,885	2,355,998	95,887		653	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	91.00	EMERGENCY	4,697	235	0	0	0	1.00
2.00	90.01	WOUND CLINIC	7,911	396	0	0	0	2.00
3.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	41,202	2,060	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	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			53,810	2,691	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	91.00	EMERGENCY	0	4,697	22,190	1,871,488		1.00
2.00	90.01	WOUND CLINIC	0	7,911	4,089	294,301		2.00
3.00	76.97	CARDIAC REHABILITATION	0	0	0	17,700		3.00
4.00	60.00	LABORATORY	0	41,202	15,798	15,798		4.00
5.00	60.00	LABORATORY	0	0	0	46,330		5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	152,458		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	53,810	42,077	2,398,075		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,138,319	3,138,319			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,851,727		2,851,727		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,077,364	12,540	11,395	10,101,299	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,967,453	299,956	272,564	2,566,690	5.00
7.00	00700	OPERATION OF PLANT	2,731,442	283,603	257,704	254,357	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	295,712	61,676	56,044	9,877	8.00
9.00	00900	HOUSEKEEPING	993,488	49,864	45,311	259,249	9.00
10.00	01000	DIETARY	7,830	102,077	92,755	28,874	10.00
11.00	01100	CAFETERIA	665,704	23,970	21,781	186,413	11.00
13.00	01300	NURSING ADMINISTRATION	709,547	23,970	21,781	197,576	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	33,390	30,341	0	14.00
15.00	01500	PHARMACY	747,582	32,350	29,396	222,567	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	650,210	49,223	44,728	124,719	16.00
20.00	02000	NURSING SCHOOL	1,245,235	283,577	257,681	372,488	20.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,822,624	220,142	200,039	1,044,679	30.00
31.00	03100	INTENSIVE CARE UNIT	850,737	21,890	19,891	236,130	31.00
43.00	04300	NURSERY	8,565	7,721	7,016	2,597	43.00
44.00	04400	SKILLED NURSING FACILITY	962,377	52,091	47,334	274,962	44.00
45.00	04500	NURSING FACILITY	250,128	45,869	41,680	74,947	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,994,646	174,282	158,366	488,158	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	17,572	3,570	3,244	5,327	52.01
53.00	05300	ANESTHESIOLOGY	82,546	2,730	2,481	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,852,656	100,889	91,676	260,450	54.00
57.00	05700	CT SCAN	302,854	0	0	24,324	57.00
58.00	05800	MRI	192,405	25,747	23,395	21,044	58.00
60.00	06000	LABORATORY	6,243,668	115,882	105,299	491,440	60.00
65.00	06500	RESPIRATORY THERAPY	792,928	17,159	15,592	208,609	65.00
66.00	06600	PHYSICAL THERAPY	1,440,026	66,390	60,327	347,451	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	799,352	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,707,013	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,617,395	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	182,201	74,441	67,643	34,016	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	15,115,608	512,013	465,255	1,530,552	88.00
88.01	08801	ELMWOOD RHC	723,857	42,645	38,751	60,814	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	999,713	36,501	33,168	89,841	90.01
91.00	09100	EMERGENCY	1,918,007	102,545	93,180	490,859	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,254,563	1,326	1,205	134,980	96.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83,213,054	2,880,029	2,617,023	10,043,990	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	4,723	4,292	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,359	30,773	27,963	6	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	88,887	80,770	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	24,083	21,884	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	51,996	47,248	0	194.02
194.03	07953	RUCHFORD POB	5,702	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	57,828	52,547	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	74,384	0	0	17,903	194.11
194.12	07962	AVON CLINIC	75,874	0	0	18,106	194.12
194.13	07963	WILLIAMSFIELD CLINIC	80,038	0	0	21,294	194.13

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
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)	83,450,411	3,138,319	2,851,727	10,101,299	83,450,411	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	17,106,663					5.00
7.00	00700	OPERATION OF PLANT	909,461	4,436,567				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	109,150	107,634	640,093			8.00
9.00	00900	HOUSEKEEPING	347,558	87,021	0	1,782,491		9.00
10.00	01000	DIETARY	59,701	178,140	0	113,610	582,987	10.00
11.00	01100	CAFETERIA	231,514	41,832	0	26,678	0	11.00
13.00	01300	NURSING ADMINISTRATION	245,698	41,832	0	26,678	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,433	58,271	0	37,163	0	14.00
15.00	01500	PHARMACY	266,073	56,456	0	36,005	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	224,040	85,901	0	54,784	0	16.00
20.00	02000	NURSING SCHOOL	556,691	494,886	0	315,616	0	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,363,372	384,182	337,150	245,014	315,862	30.00
31.00	03100	INTENSIVE CARE UNIT	291,021	38,202	52,828	24,364	49,492	31.00
43.00	04300	NURSERY	6,678	13,475	17,815	8,594	0	43.00
44.00	04400	SKILLED NURSING FACILITY	344,683	90,907	69,316	57,977	64,939	44.00
45.00	04500	NURSING FACILITY	106,395	80,049	157,867	51,051	147,900	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	983,810	304,149	0	193,973	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	7,661	6,231	5,117	3,974	4,794	52.01
53.00	05300	ANESTHESIOLOGY	22,628	4,764	0	3,038	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	594,515	176,068	0	112,288	0	54.00
57.00	05700	CT SCAN	84,363	0	0	0	0	57.00
58.00	05800	MRI	67,709	44,932	0	28,656	0	58.00
60.00	06000	LABORATORY	1,793,672	202,231	0	128,974	0	60.00
65.00	06500	RESPIRATORY THERAPY	266,690	29,945	0	19,097	0	65.00
66.00	06600	PHYSICAL THERAPY	493,573	115,861	0	73,891	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	206,112	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	440,152	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	674,893	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	92,388	129,911	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,544,176	893,538	0	0	0	88.00
88.01	08801	ELMWOOD RHC	223,315	74,423	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	298,904	63,700	0	40,625	0	90.01
91.00	09100	EMERGENCY	671,591	178,956	0	114,130	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	358,945	2,314	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,903,565	3,985,811	640,093	1,716,180	582,987	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	2,325	8,242	0	5,257	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	15,497	53,704	0	34,250	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	43,746	155,122	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	11,853	42,028	0	26,804	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	25,590	90,741	0	0	0	194.02
194.03	07953	RUCHFORD POB	1,470	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	28,460	100,919	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	23,796	0	0	0	0	194.11
194.12	07962	AVON CLINIC	24,233	0	0	0	0	194.12
194.13	07963	WILLIAMSFIELD CLINIC	26,128	0	0	0	0	194.13
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,106,663	4,436,567	640,093	1,782,491	582,987	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	1,197,892					11.00
13.00	01300	NURSING ADMINISTRATION	46,414	1,313,496				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	175,598			14.00
15.00	01500	PHARMACY	52,285	0	0	1,442,714		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29,299	0	0	0	1,262,904	16.00
20.00	02000	NURSING SCHOOL	87,504	0	108	117	0	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	245,415	431,089	8,975	14,796	87,310	30.00
31.00	03100	INTENSIVE CARE UNIT	55,471	130,862	2,575	4,852	19,431	31.00
43.00	04300	NURSERY	610	54,831	0	0	1,060	43.00
44.00	04400	SKILLED NURSING FACILITY	64,593	228,217	1,106	1,964	9,979	44.00
45.00	04500	NURSING FACILITY	17,606	68,477	31	0	3,392	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	114,676	244,301	29,135	16,282	170,042	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	1,252	16,815	0	0	4,435	52.01
53.00	05300	ANESTHESIOLOGY	0	73,107	757	60	49,523	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	61,184	0	6,371	4,568	110,023	54.00
57.00	05700	CT SCAN	5,714	0	1,574	110	111,037	57.00
58.00	05800	MRI	4,944	0	483	0	30,607	58.00
60.00	06000	LABORATORY	115,447	0	4,047	322	213,546	60.00
65.00	06500	RESPIRATORY THERAPY	49,006	0	2,153	237	20,494	65.00
66.00	06600	PHYSICAL THERAPY	81,622	0	278	2	46,760	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	31,062	0	24,670	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	66,333	0	32,281	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,606	1,027,862	74,999	73.00
76.97	07697	CARDIAC REHABILITATION	7,991	0	113	206	4,783	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	20,443	0	6,160	351,669	110,973	88.00
88.01	08801	ELMWOOD RHC	0	0	0	0	2,829	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	21,105	65,797	4,032	9,237	23,276	90.01
91.00	09100	EMERGENCY	115,311	0	5,736	10,430	111,028	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	948	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,197,892	1,313,496	175,583	1,442,714	1,262,478	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	15	0	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	0	0	194.11
194.12	07962	AVON CLINIC	0	0	0	0	157	194.12
194.13	07963	WILLIAMSFIELD CLINIC	0	0	0	0	269	194.13
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,197,892	1,313,496	175,598	1,442,714	1,262,904	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001

Period:
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Cost Center Description			NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			20.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
20.00	02000	NURSING SCHOOL	3,613,903				20.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,948,524	10,669,173	0	10,669,173	30.00
31.00	03100	INTENSIVE CARE UNIT	135,099	1,932,845	0	1,932,845	31.00
43.00	04300	NURSERY	0	128,962	0	128,962	43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,270,445	0	2,270,445	44.00
45.00	04500	NURSING FACILITY	0	1,045,392	0	1,045,392	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	553,344	6,425,164	0	6,425,164	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	79,992	0	79,992	52.01
53.00	05300	ANESTHESIOLOGY	0	241,634	0	241,634	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,370,688	0	3,370,688	54.00
57.00	05700	CT SCAN	0	529,976	0	529,976	57.00
58.00	05800	MRI	0	439,922	0	439,922	58.00
60.00	06000	LABORATORY	0	9,414,528	0	9,414,528	60.00
65.00	06500	RESPIRATORY THERAPY	45,033	1,466,943	0	1,466,943	65.00
66.00	06600	PHYSICAL THERAPY	109,205	2,835,386	0	2,835,386	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,061,196	0	1,061,196	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,245,779	0	2,245,779	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	80,215	4,478,970	0	4,478,970	73.00
76.97	07697	CARDIAC REHABILITATION	74,305	667,998	0	667,998	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	187,450	23,737,837	0	23,737,837	88.00
88.01	08801	ELMWOOD RHC	0	1,166,634	0	1,166,634	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	90,066	1,775,965	0	1,775,965	90.01
91.00	09100	EMERGENCY	390,662	4,202,435	0	4,202,435	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	1,754,281	0	1,754,281	96.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,613,903	81,942,145	0	81,942,145	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	24,839	0	24,839	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	163,567	0	163,567	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	368,525	0	368,525	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	126,652	0	126,652	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	215,575	0	215,575	194.02
194.03	07953	RUCHFORD POB	0	7,172	0	7,172	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	239,754	0	239,754	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	116,083	0	116,083	194.11
194.12	07962	AVON CLINIC	0	118,370	0	118,370	194.12
194.13	07963	WILLIAMSFIELD CLINIC	0	127,729	0	127,729	194.13
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001

Period:
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Cost Center Description		NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		20.00	24.00	25.00	26.00		
202.00	TOTAL (sum lines 118 through 201)	3,613,903	83,450,411	0	83,450,411		202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0001

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

Worksheet Non-CMS W

Date/Time Prepared:
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Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	5	GROSS SALA RIE	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	51	TOTAL PATIENT DAYS	8.00
9.00	HOUSEKEEPING	7	SQUARE FEET	9.00
10.00	DIETARY	52	TOTAL PATIENT DAYS	10.00
11.00	CAFETERIA	55	GROSS SALARIES	11.00
13.00	NURSING ADMINISTRATION	24	FTES	13.00
14.00	CENTRAL SERVICES & SUPPLY	11	COSTED REQUIS.	14.00
15.00	PHARMACY	12	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	18	GROSS CHARGES	16.00
20.00	NURSING SCHOOL	14	ASSIGNED TIME	20.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			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	12,540	11,395	23,935	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	299,956	272,564	572,520	5.00
7.00	00700	OPERATION OF PLANT	0	283,603	257,704	541,307	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	61,676	56,044	117,720	8.00
9.00	00900	HOUSEKEEPING	0	49,864	45,311	95,175	9.00
10.00	01000	DIETARY	0	102,077	92,755	194,832	10.00
11.00	01100	CAFETERIA	0	23,970	21,781	45,751	11.00
13.00	01300	NURSING ADMINISTRATION	0	23,970	21,781	45,751	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	33,390	30,341	63,731	14.00
15.00	01500	PHARMACY	0	32,350	29,396	61,746	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	49,223	44,728	93,951	16.00
20.00	02000	NURSING SCHOOL	0	283,577	257,681	541,258	20.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	220,142	200,039	420,181	30.00
31.00	03100	INTENSIVE CARE UNIT	0	21,890	19,891	41,781	31.00
43.00	04300	NURSERY	0	7,721	7,016	14,737	43.00
44.00	04400	SKILLED NURSING FACILITY	0	52,091	47,334	99,425	44.00
45.00	04500	NURSING FACILITY	0	45,869	41,680	87,549	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	174,282	158,366	332,648	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	3,570	3,244	6,814	52.01
53.00	05300	ANESTHESIOLOGY	0	2,730	2,481	5,211	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	100,889	91,676	192,565	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	25,747	23,395	49,142	58.00
60.00	06000	LABORATORY	0	115,882	105,299	221,181	60.00
65.00	06500	RESPIRATORY THERAPY	0	17,159	15,592	32,751	65.00
66.00	06600	PHYSICAL THERAPY	0	66,390	60,327	126,717	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	74,441	67,643	142,084	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	512,013	465,255	977,268	88.00
88.01	08801	ELMWOOD RHC	0	42,645	38,751	81,396	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	36,501	33,168	69,669	90.01
91.00	09100	EMERGENCY	0	102,545	93,180	195,725	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	1,326	1,205	2,531	96.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,880,029	2,617,023	5,497,052	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	4,723	4,292	9,015	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	30,773	27,963	58,736	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	88,887	80,770	169,657	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	24,083	21,884	45,967	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	51,996	47,248	99,244	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	57,828	52,547	110,375	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	0	194.11
194.12	07962	AVON CLINIC	0	0	0	0	194.12
194.13	07963	WILLIAMSFIELD CLINIC	0	0	0	0	194.13
200.00		Cross Foot Adjustments				0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0001

Period:
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,138,319	2,851,727	5,990,046	23,935	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0001

Period:
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Cost Center Description			ADMINISTRATIVE E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	578,613					5.00
7.00	00700	OPERATION OF PLANT	30,760	572,669				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,692	13,893	135,328			8.00
9.00	00900	HOUSEKEEPING	11,755	11,233	0	118,777		9.00
10.00	01000	DIETARY	2,019	22,994	0	7,570	227,483	10.00
11.00	01100	CAFETERIA	7,830	5,400	0	1,778	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,310	5,400	0	1,778	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	556	7,522	0	2,476	0	14.00
15.00	01500	PHARMACY	8,999	7,287	0	2,399	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,578	11,088	0	3,651	0	16.00
20.00	02000	NURSING SCHOOL	18,828	63,880	0	21,033	0	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	46,112	49,590	71,280	16,327	123,250	30.00
31.00	03100	INTENSIVE CARE UNIT	9,843	4,931	11,169	1,623	19,312	31.00
43.00	04300	NURSERY	226	1,739	3,766	573	0	43.00
44.00	04400	SKILLED NURSING FACILITY	11,658	11,734	14,655	3,863	25,339	44.00
45.00	04500	NURSING FACILITY	3,598	10,333	33,376	3,402	57,711	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	33,275	39,259	0	12,925	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	259	804	1,082	265	1,871	52.01
53.00	05300	ANESTHESIOLOGY	765	615	0	202	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,108	22,727	0	7,482	0	54.00
57.00	05700	CT SCAN	2,853	0	0	0	0	57.00
58.00	05800	MRI	2,290	5,800	0	1,909	0	58.00
60.00	06000	LABORATORY	60,666	26,104	0	8,594	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,020	3,865	0	1,273	0	65.00
66.00	06600	PHYSICAL THERAPY	16,694	14,955	0	4,924	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,971	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,887	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,826	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	3,125	16,769	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	153,720	115,336	0	0	0	88.00
88.01	08801	ELMWOOD RHC	7,553	9,606	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	10,110	8,222	0	2,707	0	90.01
91.00	09100	EMERGENCY	22,715	23,100	0	7,605	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	12,140	299	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	571,741	514,485	135,328	114,359	227,483	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	79	1,064	0	350	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	524	6,932	0	2,282	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	1,480	20,023	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	401	5,425	0	1,786	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	866	11,713	0	0	0	194.02
194.03	07953	RUCHFORD POB	50	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	963	13,027	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	805	0	0	0	0	194.11
194.12	07962	AVON CLINIC	820	0	0	0	0	194.12
194.13	07963	WILLIAMSFIELD CLINIC	884	0	0	0	0	194.13
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)	578,613	572,669	135,328	118,777	227,483	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	61,200					11.00
13.00	01300	NURSING ADMINISTRATION	2,371	64,078				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	74,285			14.00
15.00	01500	PHARMACY	2,671	0	0	83,629		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,497	0	0	0	118,060	16.00
20.00	02000	NURSING SCHOOL	4,471	0	46	7	0	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,535	21,031	3,797	858	8,157	30.00
31.00	03100	INTENSIVE CARE UNIT	2,834	6,384	1,089	281	1,815	31.00
43.00	04300	NURSERY	31	2,675	0	0	99	43.00
44.00	04400	SKILLED NURSING FACILITY	3,300	11,133	468	114	932	44.00
45.00	04500	NURSING FACILITY	900	3,341	13	0	317	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,859	11,918	12,325	944	15,885	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	64	820	0	0	414	52.01
53.00	05300	ANESTHESIOLOGY	0	3,566	320	4	4,627	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,126	0	2,695	265	10,278	54.00
57.00	05700	CT SCAN	292	0	666	6	10,373	57.00
58.00	05800	MRI	253	0	204	0	2,859	58.00
60.00	06000	LABORATORY	5,899	0	1,712	19	20,030	60.00
65.00	06500	RESPIRATORY THERAPY	2,504	0	911	14	1,915	65.00
66.00	06600	PHYSICAL THERAPY	4,170	0	117	0	4,368	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	13,141	0	2,305	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	28,062	0	3,016	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,525	59,580	7,006	73.00
76.97	07697	CARDIAC REHABILITATION	408	0	48	12	447	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,045	0	2,606	20,385	10,367	88.00
88.01	08801	ELMWOOD RHC	0	0	0	0	264	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	1,078	3,210	1,706	535	2,174	90.01
91.00	09100	EMERGENCY	5,892	0	2,427	605	10,372	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	401	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	61,200	64,078	74,279	83,629	118,020	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	6	0	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	0	0	194.11
194.12	07962	AVON CLINIC	0	0	0	0	15	194.12
194.13	07963	WILLIAMSFIELD CLINIC	0	0	0	0	25	194.13
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	61,200	64,078	74,285	83,629	118,060	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0001

Period:
From 07/01/2020
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Cost Center Description			NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			20.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
20.00	02000	NURSING SCHOOL	650,405				20.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		775,592	0	775,592	30.00
31.00	03100	INTENSIVE CARE UNIT		101,621	0	101,621	31.00
43.00	04300	NURSERY		23,852	0	23,852	43.00
44.00	04400	SKILLED NURSING FACILITY		183,272	0	183,272	44.00
45.00	04500	NURSING FACILITY		200,717	0	200,717	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		466,194	0	466,194	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM		12,406	0	12,406	52.01
53.00	05300	ANESTHESIOLOGY		15,310	0	15,310	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		259,863	0	259,863	54.00
57.00	05700	CT SCAN		14,248	0	14,248	57.00
58.00	05800	MRI		62,507	0	62,507	58.00
60.00	06000	LABORATORY		345,369	0	345,369	60.00
65.00	06500	RESPIRATORY THERAPY		52,747	0	52,747	65.00
66.00	06600	PHYSICAL THERAPY		172,768	0	172,768	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		22,417	0	22,417	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		45,965	0	45,965	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		90,937	0	90,937	73.00
76.97	07697	CARDIAC REHABILITATION		162,974	0	162,974	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		1,284,352	0	1,284,352	88.00
88.01	08801	ELMWOOD RHC		98,963	0	98,963	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	09000	CLINIC		0	0	0	90.00
90.01	09001	WOUND CLINIC		99,624	0	99,624	90.01
91.00	09100	EMERGENCY		269,603	0	269,603	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		15,691	0	15,691	96.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,776,992	0	4,776,992	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN		10,508	0	10,508	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES		68,480	0	68,480	192.00
192.01	19201	CANTON RHC RENTED SPACE		191,160	0	191,160	192.01
193.00	19300	NONPAID WORKERS		0	0	0	193.00
193.02	19302	FOUNDATION		0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC		53,579	0	53,579	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY		0	0	0	194.01
194.02	07952	FRESENIUS		111,823	0	111,823	194.02
194.03	07953	RUCHFORD POB		50	0	50	194.03
194.04	07954	EP COLEMAN RENTAL SPACE		124,365	0	124,365	194.04
194.05	07955	FARMINGTON POB		0	0	0	194.05
194.06	07956	LEWISTON POB		0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY		0	0	0	194.07
194.08	07958	KELLEY HOME		0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE		0	0	0	194.09
194.10	07960	RETAIL PHARMACY		0	0	0	194.10
194.11	07961	WELLNESS CENTER		847	0	847	194.11
194.12	07962	AVON CLINIC		878	0	878	194.12
194.13	07963	WILLIAMSFIELD CLINIC		959	0	959	194.13
200.00		Cross Foot Adjustments	650,405	650,405	0	650,405	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description		NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		20.00	24.00	25.00	26.00		
202.00	TOTAL (sum lines 118 through 201)	650,405	5,990,046	0	5,990,046		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0001

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

Worksheet B-1

Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	362,142					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		362,142				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,447	1,447	33,317,879			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	34,613	34,613	8,465,930	-17,106,663	66,343,748	5.00
7.00	00700	OPERATION OF PLANT	32,726	32,726	838,965	0	3,527,106	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,117	7,117	32,579	0	423,309	8.00
9.00	00900	HOUSEKEEPING	5,754	5,754	855,098	0	1,347,912	9.00
10.00	01000	DIETARY	11,779	11,779	95,238	0	231,536	10.00
11.00	01100	CAFETERIA	2,766	2,766	614,859	0	897,868	11.00
13.00	01300	NURSING ADMINISTRATION	2,766	2,766	651,680	0	952,874	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,853	3,853	0	0	63,731	14.00
15.00	01500	PHARMACY	3,733	3,733	734,108	0	1,031,895	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,680	5,680	411,369	0	868,880	16.00
20.00	02000	NURSING SCHOOL	32,723	32,723	1,228,605	0	2,158,981	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	25,403	25,403	3,445,739	0	5,287,484	30.00
31.00	03100	INTENSIVE CARE UNIT	2,526	2,526	778,845	0	1,128,648	31.00
43.00	04300	NURSERY	891	891	8,565	0	25,899	43.00
44.00	04400	SKILLED NURSING FACILITY	6,011	6,011	906,928	0	1,336,764	44.00
45.00	04500	NURSING FACILITY	5,293	5,293	247,203	0	412,624	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,111	20,111	1,610,126	0	3,815,452	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	412	412	17,572	0	29,713	52.01
53.00	05300	ANESTHESIOLOGY	315	315	0	0	87,757	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,642	11,642	859,062	0	2,305,671	54.00
57.00	05700	CT SCAN	0	0	80,229	0	327,178	57.00
58.00	05800	MRI	2,971	2,971	69,411	0	262,591	58.00
60.00	06000	LABORATORY	13,372	13,372	1,620,951	0	6,956,289	60.00
65.00	06500	RESPIRATORY THERAPY	1,980	1,980	688,070	0	1,034,288	65.00
66.00	06600	PHYSICAL THERAPY	7,661	7,661	1,146,022	0	1,914,194	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	799,352	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,707,013	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,617,395	73.00
76.97	07697	CARDIAC REHABILITATION	8,590	8,590	112,199	0	358,301	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	59,083	59,083	5,048,329	0	17,623,428	88.00
88.01	08801	ELMWOOD RHC	4,921	4,921	200,588	0	866,067	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	4,212	4,212	296,329	0	1,159,223	90.01
91.00	09100	EMERGENCY	11,833	11,833	1,619,035	0	2,604,591	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	153	153	445,214	0	1,392,074	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	332,337	332,337	33,128,848	-17,106,663	65,556,088	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	545	545	0	0	9,015	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	3,551	3,551	21	0	60,101	192.00
192.01	19201	CANTON RHC RENTED SPACE	10,257	10,257	0	0	169,657	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	2,779	2,779	0	0	45,967	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	6,000	6,000	0	0	99,244	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	5,702	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	6,673	6,673	0	0	110,375	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	59,052	0	92,287	194.11
194.12	07962	AVON CLINIC	0	0	59,721	0	93,980	194.12
194.13	07963	WILLIAMSFIELD CLINIC	0	0	70,237	0	101,332	194.13

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0001

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

Worksheet B-1

Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
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)	3,138,319	2,851,727	10,101,299		17,106,663	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.665990	7.874610	0.303180		0.257849	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			23,935		578,613	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000718		0.008721	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: 14-0001

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

Worksheet B-1

Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	293,356					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,117	13,510				8.00
9.00	00900	HOUSEKEEPING	5,754	0	184,808			9.00
10.00	01000	DIETARY	11,779	0	11,779	13,134		10.00
11.00	01100	CAFETERIA	2,766	0	2,766	0	16,819,080	11.00
13.00	01300	NURSING ADMINISTRATION	2,766	0	2,766	0	651,680	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,853	0	3,853	0	0	14.00
15.00	01500	PHARMACY	3,733	0	3,733	0	734,108	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,680	0	5,680	0	411,369	16.00
20.00	02000	NURSING SCHOOL	32,723	0	32,723	0	1,228,605	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	25,403	7,116	25,403	7,116	3,445,739	30.00
31.00	03100	INTENSIVE CARE UNIT	2,526	1,115	2,526	1,115	778,845	31.00
43.00	04300	NURSERY	891	376	891	0	8,565	43.00
44.00	04400	SKILLED NURSING FACILITY	6,011	1,463	6,011	1,463	906,928	44.00
45.00	04500	NURSING FACILITY	5,293	3,332	5,293	3,332	247,203	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,111	0	20,111	0	1,610,126	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	412	108	412	108	17,572	52.01
53.00	05300	ANESTHESIOLOGY	315	0	315	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,642	0	11,642	0	859,062	54.00
57.00	05700	CT SCAN	0	0	0	0	80,229	57.00
58.00	05800	MRI	2,971	0	2,971	0	69,411	58.00
60.00	06000	LABORATORY	13,372	0	13,372	0	1,620,951	60.00
65.00	06500	RESPIRATORY THERAPY	1,980	0	1,980	0	688,070	65.00
66.00	06600	PHYSICAL THERAPY	7,661	0	7,661	0	1,146,022	66.00
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
76.97	07697	CARDIAC REHABILITATION	8,590	0	0	0	112,199	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	59,083	0	0	0	287,032	88.00
88.01	08801	ELMWOOD RHC	4,921	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	4,212	0	4,212	0	296,329	90.01
91.00	09100	EMERGENCY	11,833	0	11,833	0	1,619,035	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	153	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	263,551	13,510	177,933	13,134	16,819,080	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	545	0	545	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	3,551	0	3,551	0	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	10,257	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	2,779	0	2,779	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	6,000	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	6,673	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	0	0	194.11
194.12	07962	AVON CLINIC	0	0	0	0	0	194.12
194.13	07963	WILLIAMSFIELD CLINIC	0	0	0	0	0	194.13
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0001

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

Worksheet B-1

Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	4,436,567	640,093	1,782,491	582,987	1,197,892	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.123492	47.379201	9.645097	44.387620	0.071222	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	572,669	135,328	118,777	227,483	61,200	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.952130	10.016876	0.642705	17.320161	0.003639	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: 14-0001

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATIO N (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NURSING SCHOOL (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	20.00	
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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	10,780					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,518,852				14.00
15.00	01500	PHARMACY	0	0	2,981,366			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	218,087,653		16.00
20.00	02000	NURSING SCHOOL	0	2,775	242	0	321,000	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,538	230,964	30,575	15,076,905	173,075	30.00
31.00	03100	INTENSIVE CARE UNIT	1,074	66,253	10,026	3,355,458	12,000	31.00
43.00	04300	NURSERY	450	0	0	183,000	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,873	28,460	4,058	1,723,251	0	44.00
45.00	04500	NURSING FACILITY	562	792	0	585,674	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,005	749,761	33,647	29,363,190	49,150	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	138	0	0	765,843	0	52.01
53.00	05300	ANESTHESIOLOGY	600	19,493	125	8,551,772	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	163,957	9,440	18,998,930	0	54.00
57.00	05700	CT SCAN	0	40,504	228	19,174,065	0	57.00
58.00	05800	MRI	0	12,423	0	5,285,255	0	58.00
60.00	06000	LABORATORY	0	104,150	666	36,882,683	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	55,416	490	3,538,934	4,000	65.00
66.00	06600	PHYSICAL THERAPY	0	7,142	4	8,074,607	9,700	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	799,352	0	4,260,015	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,707,013	0	5,574,358	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	92,793	2,124,073	12,950,928	7,125	73.00
76.97	07697	CARDIAC REHABILITATION	0	2,918	426	826,004	6,600	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	158,531	726,724	19,163,039	16,650	88.00
88.01	08801	ELMWOOD RHC	0	0	0	488,445	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	540	103,767	19,088	4,019,286	8,000	90.01
91.00	09100	EMERGENCY	0	147,613	21,554	19,172,492	34,700	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	24,384	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,780	4,518,461	2,981,366	218,014,134	321,000	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	391	0	0	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	0	0	194.11
194.12	07962	AVON CLINIC	0	0	0	27,060	0	194.12
194.13	07963	WILLIAMSFIELD CLINIC	0	0	0	46,459	0	194.13
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0001

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

Worksheet B-1

Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description		NURSING ADMINISTRATIO N (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NURSING SCHOOL (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	20.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1,313,496	175,598	1,442,714	1,262,904	3,613,903	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	121.845640	0.038859	0.483910	0.005791	11.258265	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	64,078	74,285	83,629	118,060	650,405	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	5.944156	0.016439	0.028051	0.000541	2.026184	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 8:29 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,669,173		10,669,173	0	10,669,173	30.00
31.00	03100	INTENSIVE CARE UNIT	1,932,845		1,932,845	0	1,932,845	31.00
43.00	04300	NURSERY	128,962		128,962	0	128,962	43.00
44.00	04400	SKILLED NURSING FACILITY	2,270,445		2,270,445	0	2,270,445	44.00
45.00	04500	NURSING FACILITY	1,045,392		1,045,392	0	1,045,392	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,425,164		6,425,164	0	6,425,164	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	79,992		79,992	0	79,992	52.01
53.00	05300	ANESTHESIOLOGY	241,634		241,634	0	241,634	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,370,688		3,370,688	0	3,370,688	54.00
57.00	05700	CT SCAN	529,976		529,976	0	529,976	57.00
58.00	05800	MRI	439,922		439,922		439,922	58.00
60.00	06000	LABORATORY	9,414,528		9,414,528	15,798	9,430,326	60.00
65.00	06500	RESPIRATORY THERAPY	1,466,943	0	1,466,943	0	1,466,943	65.00
66.00	06600	PHYSICAL THERAPY	2,835,386	0	2,835,386		2,835,386	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,061,196		1,061,196	0	1,061,196	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,245,779		2,245,779	0	2,245,779	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,478,970		4,478,970	0	4,478,970	73.00
76.97	07697	CARDIAC REHABILITATION	667,998		667,998	0	667,998	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	23,737,837		23,737,837	0	23,737,837	88.00
88.01	08801	ELMWOOD RHC	1,166,634		1,166,634	0	1,166,634	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,775,965		1,775,965	4,089	1,780,054	90.01
91.00	09100	EMERGENCY	4,202,435		4,202,435	22,190	4,224,625	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,220,493		2,220,493		2,220,493	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,754,281		1,754,281	0	1,754,281	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	84,162,638	0	84,162,638	42,077	84,204,715	200.00
201.00		Less Observation Beds	2,220,493		2,220,493		2,220,493	201.00
202.00		Total (see instructions)	81,942,145	0	81,942,145	42,077	81,984,222	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 8:29 am

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,209,506		12,209,506		30.00
31.00	03100	INTENSIVE CARE UNIT	3,355,458		3,355,458		31.00
43.00	04300	NURSERY	183,000		183,000		43.00
44.00	04400	SKILLED NURSING FACILITY	1,723,251		1,723,251		44.00
45.00	04500	NURSING FACILITY	585,674		585,674		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,313,595	22,049,595	29,363,190	0.218817	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000
52.01	05201	DELIVERY ROOM & LABOR ROOM	745,984	19,859	765,843	0.104450	0.000000
53.00	05300	ANESTHESIOLOGY	2,435,855	6,115,917	8,551,772	0.028255	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,692,750	17,306,180	18,998,930	0.177415	0.000000
57.00	05700	CT SCAN	2,942,469	16,231,596	19,174,065	0.027640	0.000000
58.00	05800	MRI	274,340	5,010,915	5,285,255	0.083236	0.000000
60.00	06000	LABORATORY	4,925,694	31,956,989	36,882,683	0.255256	0.000000
65.00	06500	RESPIRATORY THERAPY	1,283,649	2,255,285	3,538,934	0.414516	0.000000
66.00	06600	PHYSICAL THERAPY	1,389,309	6,685,298	8,074,607	0.351148	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,353,677	1,906,338	4,260,015	0.249106	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,644,787	2,929,571	5,574,358	0.402877	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	5,616,811	7,334,117	12,950,928	0.345842	0.000000
76.97	07697	CARDIAC REHABILITATION	10,331	815,673	826,004	0.808710	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	19,163,039	19,163,039		88.00
88.01	08801	ELMWOOD RHC	0	488,445	488,445		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000
90.01	09001	WOUND CLINIC	42,173	3,977,113	4,019,286	0.441861	0.000000
91.00	09100	EMERGENCY	3,313,488	15,859,004	19,172,492	0.219191	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	699,296	2,168,103	2,867,399	0.774393	0.000000
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	4,609,284	4,609,284	0.380597	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	55,741,097	166,882,321	222,623,418		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	55,741,097	166,882,321	222,623,418		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.218817		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.104450		52.01
53.00	05300	ANESTHESIOLOGY	0.028255		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177415		54.00
57.00	05700	CT SCAN	0.027640		57.00
58.00	05800	MRI	0.083236		58.00
60.00	06000	LABORATORY	0.255684		60.00
65.00	06500	RESPIRATORY THERAPY	0.414516		65.00
66.00	06600	PHYSICAL THERAPY	0.351148		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.249106		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.402877		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.345842		73.00
76.97	07697	CARDIAC REHABILITATION	0.808710		76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	ELMWOOD RHC			88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CLINIC	0.442878		90.01
91.00	09100	EMERGENCY	0.220348		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.774393		92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.380597		96.00
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 ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/23/2021 8:29 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	775,592	0	775,592	7,116	108.99	30.00
31.00	INTENSIVE CARE UNIT	101,621		101,621	1,115	91.14	31.00
43.00	NURSERY	23,852		23,852	376	63.44	43.00
44.00	SKILLED NURSING FACILITY	183,272		183,272	1,463	125.27	44.00
45.00	NURSING FACILITY	200,717		200,717	3,332	60.24	45.00
200.00	Total (lines 30 through 199)	1,285,054		1,285,054	13,402		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	2,973	324,027				30.00
31.00	INTENSIVE CARE UNIT	490	44,659				31.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	1,036	129,780				44.00
45.00	NURSING FACILITY	0	0				45.00
200.00	Total (lines 30 through 199)	4,499	498,466				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Prepared: 11/23/2021 8:29 am			
				Title XVIII		Hospital		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	466,194	29,363,190	0.015877	3,455,533	54,863	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00	
52.01	05201	DELIVERY ROOM & LABOR ROOM	12,406	765,843	0.016199	0	0	52.01	
53.00	05300	ANESTHESIOLOGY	15,310	8,551,772	0.001790	656,158	1,175	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	259,863	18,998,930	0.013678	935,469	12,795	54.00	
57.00	05700	CT SCAN	14,248	19,174,065	0.000743	1,470,908	1,093	57.00	
58.00	05800	MRI	62,507	5,285,255	0.011827	144,631	1,711	58.00	
60.00	06000	LABORATORY	345,369	36,882,683	0.009364	2,736,375	25,623	60.00	
65.00	06500	RESPIRATORY THERAPY	52,747	3,538,934	0.014905	1,166,903	17,393	65.00	
66.00	06600	PHYSICAL THERAPY	172,768	8,074,607	0.021396	799,360	17,103	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,417	4,260,015	0.005262	1,097,498	5,775	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,965	5,574,358	0.008246	1,226,649	10,115	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	90,937	12,950,928	0.007022	3,423,516	24,040	73.00	
76.97	07697	CARDIAC REHABILITATION	162,974	826,004	0.197304	4,592	906	76.97	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,284,352	19,163,039	0.067022	0	0	88.00	
88.01	08801	ELMWOOD RHC	98,963	488,445	0.202608	0	0	88.01	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00	
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00	
90.01	09001	WOUND CLINIC	99,624	4,019,286	0.024786	16,393	406	90.01	
91.00	09100	EMERGENCY	269,603	19,172,492	0.014062	1,833,056	25,776	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	161,419	2,867,399	0.056295	321,347	18,090	92.00	
	OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	15,691	4,609,284	0.003404	0	0	96.00	
200.00		Total (lines 50 through 199)	3,653,357	204,566,529		19,288,388	216,864	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0001		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/23/2021 8:29 am		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
	INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	1,948,524	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	135,099	0	0	0	0	31.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00		
45.00	04500	NURSING FACILITY	0	0	0	0	0	0	45.00		
200.00		Total (lines 30 through 199)	0	2,083,623	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	1,948,524	7,116	273.82	2,973	30.00			
31.00	03100	INTENSIVE CARE UNIT		135,099	1,115	121.17	490	31.00			
43.00	04300	NURSERY		0	376	0.00	0	43.00			
44.00	04400	SKILLED NURSING FACILITY		0	1,463	0.00	1,036	44.00			
45.00	04500	NURSING FACILITY		0	3,332	0.00	0	45.00			
200.00		Total (lines 30 through 199)		2,083,623	13,402		4,499	200.00			
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost					
					9.00	13.00					
	INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	814,067	0				30.00			
31.00	03100	INTENSIVE CARE UNIT	59,373	0				31.00			
43.00	04300	NURSERY	0	0				43.00			
44.00	04400	SKILLED NURSING FACILITY	0					44.00			
45.00	04500	NURSING FACILITY	0					45.00			
200.00		Total (lines 30 through 199)	873,440	0				200.00			

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	553,344	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.01
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	45,033	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	109,205	0	0	66.00
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	80,215	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	74,305	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	187,450	0	0	88.00
88.01	08801 ELMWOOD RHC	0	0	0	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 WOUND CLINIC	0	0	90,066	0	0	90.01
91.00	09100 EMERGENCY	0	0	390,662	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	405,531	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00	Total (lines 50 through 199)	0	0	1,935,811	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0001		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/23/2021 8:29 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	553,344	553,344	29,363,190	0.018845	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0	0	765,843	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	8,551,772	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	18,998,930	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	19,174,065	0.000000	57.00
58.00	05800	MRI	0	0	0	5,285,255	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	36,882,683	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	45,033	45,033	3,538,934	0.012725	65.00
66.00	06600	PHYSICAL THERAPY	0	109,205	109,205	8,074,607	0.013524	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,260,015	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,574,358	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	80,215	80,215	12,950,928	0.006194	73.00
76.97	07697	CARDIAC REHABILITATION	0	74,305	74,305	826,004	0.089957	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	187,450	187,450	19,163,039	0.009782	88.00
88.01	08801	ELMWOOD RHC	0	0	0	488,445	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	0	90,066	90,066	4,019,286	0.022408	90.01
91.00	09100	EMERGENCY	0	390,662	390,662	19,172,492	0.020376	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	405,531	405,531	2,867,399	0.141428	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	4,609,284	0.000000	96.00
200.00		Total (lines 50 through 199)	0	1,935,811	1,935,811	204,566,529		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0001

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

Worksheet D
Part IV
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11/23/2021 8:29 am

				Title XVIII		Hospital	PPS		
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.018845	3,455,533	65,120	5,096,166	96,037	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.01	
53.00	05300	ANESTHESIOLOGY	0.000000	656,158	0	718,191	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	935,469	0	5,120,335	0	54.00	
57.00	05700	CT SCAN	0.000000	1,470,908	0	5,404,422	0	57.00	
58.00	05800	MRI	0.000000	144,631	0	1,287,059	0	58.00	
60.00	06000	LABORATORY	0.000000	2,736,375	0	3,543,979	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.012725	1,166,903	14,849	636,587	8,101	65.00	
66.00	06600	PHYSICAL THERAPY	0.013524	799,360	10,811	41,678	564	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,097,498	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,226,649	0	1,198,685	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.006194	3,423,516	21,205	1,737,013	10,759	73.00	
76.97	07697	CARDIAC REHABILITATION	0.089957	4,592	413	403,700	36,316	76.97	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.009782	0	0	0	0	88.00	
88.01	08801	ELMWOOD RHC	0.000000	0	0	0	0	88.01	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00	
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
90.01	09001	WOUND CLINIC	0.022408	16,393	367	1,760,140	39,441	90.01	
91.00	09100	EMERGENCY	0.020376	1,833,056	37,350	3,891,233	79,288	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.141428	321,347	45,447	1,665,395	235,533	92.00	
	OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00	
200.00		Total (lines 50 through 199)		19,288,388	195,562	32,504,583	506,039	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet D
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				Title XVIII	Hospital	PPS
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0		52.01
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	ELMWOOD RHC	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/23/2021 8:29 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.218817	5,096,166	0	0	1,115,128	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.104450	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.028255	718,191	0	0	20,292	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177415	5,120,335	0	0	908,424	54.00
57.00	05700	CT SCAN	0.027640	5,404,422	0	0	149,378	57.00
58.00	05800	MRI	0.083236	1,287,059	0	0	107,130	58.00
60.00	06000	LABORATORY	0.255256	3,543,979	1,309	0	904,622	60.00
65.00	06500	RESPIRATORY THERAPY	0.414516	636,587	0	0	263,875	65.00
66.00	06600	PHYSICAL THERAPY	0.351148	41,678	0	0	14,635	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.249106	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.402877	1,198,685	0	0	482,923	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.345842	1,737,013	0	1,900	600,732	73.00
76.97	07697	CARDIAC REHABILITATION	0.808710	403,700	0	0	326,476	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	ELMWOOD RHC						88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.441861	1,760,140	0	0	777,737	90.01
91.00	09100	EMERGENCY	0.219191	3,891,233	0	0	852,923	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.774393	1,665,395	0	0	1,289,670	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.380597	0	0	0	0	96.00
200.00		Subtotal (see instructions)		32,504,583	1,309	1,900	7,813,945	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		32,504,583	1,309	1,900	7,813,945	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/23/2021 8:29 am

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0		52.01
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	334	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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	657		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	ELMWOOD RHC				88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	334	657		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	334	657		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0001 Component CCN: 14-5572		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/23/2021 8:29 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	553,344	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	45,033	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	109,205	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	80,215	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	74,305	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	187,450	0	0	0	88.00
88.01	08801	ELMWOOD RHC	0	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	90,066	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	390,662	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	1,530,280	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0001 Component CCN: 14-5572		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/23/2021 8:29 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0		553,344	553,344	29,363,190	0.018845	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	0.000000	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0		0	0	765,843	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0		0	0	8,551,772	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		0	0	18,998,930	0.000000	54.00
57.00	05700	CT SCAN	0		0	0	19,174,065	0.000000	57.00
58.00	05800	MRI	0		0	0	5,285,255	0.000000	58.00
60.00	06000	LABORATORY	0		0	0	36,882,683	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0		45,033	45,033	3,538,934	0.012725	65.00
66.00	06600	PHYSICAL THERAPY	0		109,205	109,205	8,074,607	0.013524	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	4,260,015	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	5,574,358	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		80,215	80,215	12,950,928	0.006194	73.00
76.97	07697	CARDIAC REHABILITATION	0		74,305	74,305	826,004	0.089957	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		187,450	187,450	19,163,039	0.009782	88.00
88.01	08801	ELMWOOD RHC	0		0	0	488,445	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0.000000	89.00
90.00	09000	CLINIC	0		0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	0		90,066	90,066	4,019,286	0.022408	90.01
91.00	09100	EMERGENCY	0		390,662	390,662	19,172,492	0.020376	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	2,867,399	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	4,609,284	0.000000	96.00
200.00		Total (lines 50 through 199)	0		1,530,280	1,530,280	204,566,529		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0001

Period:

Worksheet D

Component CCN: 14-5572

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

Part IV
Date/Time Prepared:
11/23/2021 8:29 am

				Title XVIII		Skilled Nursing Facility	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.018845	6,982	132	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.000000	426	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,973	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	16,390	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.012725	115,799	1,474	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.013524	589,117	7,967	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	115,280	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	0.006194	130,642	809	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.089957	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.009782	0	0	0	0	88.00
88.01	08801	ELMWOOD RHC	0.000000	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.022408	3,433	77	0	0	90.01
91.00	09100	EMERGENCY	0.020376	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		982,042	10,459	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN:14-0001

Component CCN:14-5572

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

Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 8:29 am

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost	
		21.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
52.01	05201 DELIVERY ROOM & LABOR ROOM	0	0	52.01
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
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	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
88.01	08801 ELMWOOD RHC	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	0	0	90.00
90.01	09001 WOUND CLINIC	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00	Total (lines 50 through 199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN:14-0001 Component CCN:14-5572		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/23/2021 8:29 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.218817	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.104450	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.028255	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177415	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0.027640	0	0	0	0	0	57.00
58.00	05800	MRI	0.083236	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0.255256	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.414516	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.351148	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.249106	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.402877	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.345842	0		331	434	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.808710	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
88.01	08801	ELMWOOD RHC							88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER							89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.441861	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.219191	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.774393	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.380597	0	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	331	434	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	331	434	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:14-0001		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/23/2021 8:29 am	
			Component CCN:14-5572					
			Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description			Costs					
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	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				
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0				
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0				
53.00	05300	ANESTHESIOLOGY	0	0				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0				
57.00	05700	CT SCAN	0	0				
58.00	05800	MRI	0	0				
60.00	06000	LABORATORY	0	0				
65.00	06500	RESPIRATORY THERAPY	0	0				
66.00	06600	PHYSICAL THERAPY	0	0				
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0				
73.00	07300	DRUGS CHARGED TO PATIENTS	114	150				
76.97	07697	CARDIAC REHABILITATION	0	0				
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						
88.01	08801	ELMWOOD RHC						
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						
90.00	09000	CLINIC	0	0				
90.01	09001	WOUND CLINIC	0	0				
91.00	09100	EMERGENCY	0	0				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0				
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0				
200.00		Subtotal (see instructions)	114	150				
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0					
202.00		Net Charges (line 200 - line 201)	114	150				

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/23/2021 8:29 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,116	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,116	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)		5,635	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)		2,973	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		10,669,173	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		10,669,173	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		10,669,173	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)		1,499.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,457,478	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)		4,457,478	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0001

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

Worksheet D-1

Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,932,845	1,115	1,733.49	490	849,410	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)					5,072,682	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,379,570	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)					1,242,126	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					412,426	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,654,552	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					8,725,018	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)					1,481	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,499.32	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,220,493	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-0001		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/23/2021 8:29 am	
				Title XVIII		Hospital		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
		1.00	2.00	3.00	4.00	5.00			
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost	775,592	10,669,173	0.072695	2,220,493	161,419	90.00		
91.00	Nursing School cost	1,948,524	10,669,173	0.182631	2,220,493	405,531	91.00		
92.00	Allied health cost	0	10,669,173	0.000000	2,220,493	0	92.00		
93.00	All other Medical Education	0	10,669,173	0.000000	2,220,493	0	93.00		

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1
		Component CCN: 14-5572		Date/Time Prepared: 11/23/2021 8:29 am
		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)		1,463	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,463	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)		1,463	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)		1,036	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,270,445	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)		2,270,445	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)		2,270,445	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: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1
				Component CCN: 14-5572		Date/Time Prepared: 11/23/2021 8:29 am
				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)					2,270,445	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					1,551.91	71.00
72.00 Program routine service cost (line 9 x line 71)					1,607,779	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					1,607,779	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)					0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00 Inpatient routine service cost per diem limitation					0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)					1,607,779	83.00
84.00 Program inpatient ancillary services (see instructions)					336,722	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)					1,944,501	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: 14-0001 Component CCN: 14-5572		Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/23/2021 8:29 am	
		Title XVIII		Skilled Nursing Facility	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	0	0	0.000000	0	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/23/2021 8:29 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		4,831,196		30.00
31.00	03100	INTENSIVE CARE UNIT		1,679,110		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.218817	3,455,533	756,129	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.104450	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.028255	656,158	18,540	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177415	935,469	165,966	54.00
57.00	05700	CT SCAN	0.027640	1,470,908	40,656	57.00
58.00	05800	MRI	0.083236	144,631	12,039	58.00
60.00	06000	LABORATORY	0.255684	2,736,375	699,647	60.00
65.00	06500	RESPIRATORY THERAPY	0.414516	1,166,903	483,700	65.00
66.00	06600	PHYSICAL THERAPY	0.351148	799,360	280,694	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.249106	1,097,498	273,393	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.402877	1,226,649	494,189	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.345842	3,423,516	1,183,996	73.00
76.97	07697	CARDIAC REHABILITATION	0.808710	4,592	3,714	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	ELMWOOD RHC	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.442878	16,393	7,260	90.01
91.00	09100	EMERGENCY	0.220348	1,833,056	403,910	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.774393	321,347	248,849	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.380597	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		19,288,388	5,072,682	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		19,288,388		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN:14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/23/2021 8:29 am	
		Component CCN:14-5572			
		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
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.218817	6,982	1,528	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
52.01	05201 DELIVERY ROOM & LABOR ROOM	0.104450	0	0	52.01
53.00	05300 ANESTHESIOLOGY	0.028255	426	12	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.177415	3,973	705	54.00
57.00	05700 CT SCAN	0.027640	0	0	57.00
58.00	05800 MRI	0.083236	0	0	58.00
60.00	06000 LABORATORY	0.255684	16,390	4,191	60.00
65.00	06500 RESPIRATORY THERAPY	0.414516	115,799	48,001	65.00
66.00	06600 PHYSICAL THERAPY	0.351148	589,117	206,867	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.249106	115,280	28,717	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.402877	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.345842	130,642	45,181	73.00
76.97	07697 CARDIAC REHABILITATION	0.808710	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 ELMWOOD RHC	0.000000		0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 WOUND CLINIC	0.442878	3,433	1,520	90.01
91.00	09100 EMERGENCY	0.220348	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.774393	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.380597	0	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		982,042	336,722	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		982,042		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/23/2021 8:29 am
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		1,346,148	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		4,489,593	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		46,752	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		128,918	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		38.65	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.28	30.00
31.00	Percentage of Medicaid patient days (see instructions)		20.85	31.00
32.00	Sum of lines 30 and 31		23.13	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.30	33.00
34.00	Disproportionate share adjustment (see instructions)		121,092	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/23/2021 8:29 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		8,350,599,096	8,290,014,521	35.00
35.01	Factor 3 (see instructions)		0.000058422	0.000082706	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		487,861	685,637	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		122,632	512,819	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		635,451		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		6,767,954		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))		7,566,901		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			7,566,901	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			459,082	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			357,677	53.00
54.00	Special add-on payments for new technologies			101,665	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			873,440	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			195,562	58.00
59.00	Total (sum of amounts on lines 49 through 58)			9,554,327	59.00
60.00	Primary payer payments			22,237	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			9,532,090	61.00
62.00	Deductibles billed to program beneficiaries			856,340	62.00
63.00	Coinsurance billed to program beneficiaries			24,640	63.00
64.00	Allowable bad debts (see instructions)			312,438	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			203,085	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			249,886	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			8,854,195	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			37,286	70.93
70.94	HRR adjustment amount (see instructions)			-50,882	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/23/2021 8:29 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2020	229,793	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2021	824,199	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,894,591	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		9,387,637	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		506,954	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		38,892	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		3,834	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF DSH PAYMENT PERCENTAGE				Provider CCN: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet DSH Date/Time Prepared: 11/23/2021 8:29 am	
				Title XVIII	Hospital	PPS	
				Original .mcx Values	Adjusted .mcx Values	HFS Look Up	Override Value
				1.00	2.00	3.00	4.00
							Revised Value
							5.00
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	2.28	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	20.85	0.00				2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	23.13	0.00				3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	SCH					4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	38.65	0.00				5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	8.30	0.00				6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes					7.00
8.00	S-2, Line 22	Yes					8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No					9.00
10.00	S-2, Line 45	No					10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes					11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No					13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	1,334	0				15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	0	0				16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0				17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0				18.00
18.01	N/A	0	0				18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	152	0				19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0				20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	1,486	0				21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	7,126	0				22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0				23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0				24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0				25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	7,126	0				26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	20.85	0.00				27.00

CALCULATION OF DSH PAYMENT PERCENTAGE				Provider CCN: 14-0001		Period: From 07/01/2020 To 06/30/2021		Worksheet DSH Date/Time Prepared: 11/23/2021 8:29 am	
				Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised			
		Condition	Percentage	Condition	Percentage	Condition			
		1.00	2.00	3.00	4.00	5.00			
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE									
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	8.30		0.00	True	28.00		
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00		
30.00	Line 28 or 29 as applicable		8.30		0.00		30.00		
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		8.30		0.00		31.00		
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value			
		1.00	2.00	3.00	4.00	5.00			
DETERMINATION OF PROVIDER TYPE									
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00		
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00		
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00		
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	True				True	35.00		
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00		

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet DSH Date/Time Prepared: 11/23/2021 8:29 am
		Title XVIII	Hospital	PPS
		Revised Percentage 6.00		
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE				
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	6.42	28.00	
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00	
30.00	Line 28 or 29 as applicable	6.42	30.00	
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	6.42	31.00	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/23/2021 8:29 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,346,148	0	1,346,148		1,346,148
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,489,593	0		4,489,593	4,489,593
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	46,752	0	0		46,752
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	128,918	0		128,918	128,918
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0830	0.0830	0.0830	0.0830	
11.00	Disproportionate share adjustment (see instructions)	34.00	121,092	0	27,933	93,159	121,092
11.01	Uncompensated care payments	36.00	635,451	0	110,946	524,505	635,451
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	6,767,954	0	1,485,027	5,282,927	6,767,954
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	7,566,901	0	1,722,131	5,844,770	7,566,901
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,566,901	0	1,722,131	5,844,770	7,566,901

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/23/2021 8:29 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	459,082	0	120,637	338,445	459,082
17.00	Special add-on payments for new technologies	54.00	101,665	0	0	101,665	101,665
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	1,842,768	6,284,880	8,127,648
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	441,765	0	105,716	336,049	441,765
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	17,317	0	14,921	2,396	17,317
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	459,082	0	120,637	338,445	459,082
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.124700	0.131140	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			229,793		229,793
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				824,199	824,199
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/23/2021 8:29 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		991	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		7,307,906	2.00
3.00	OPPS payments		5,668,743	3.00
4.00	Outlier payment (see instructions)		10,842	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.862	5.00
6.00	Line 2 times line 5		6,299,415	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		90.16	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		506,039	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		991	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		3,209	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)		3,209	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)		3,209	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,218	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)		991	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)		6,185,624	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		82,202	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,050,156	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)		5,054,257	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)		5,054,257	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		5,054,257	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)		313,134	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		203,537	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		230,979	36.00
37.00	Subtotal (see instructions)		5,257,794	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)		0	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)		5,257,794	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		0	40.03
41.00	Interim payments		5,118,584	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		139,210	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	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)		327	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: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/23/2021 8:29 am	
		Title XVIII	Hospital	PPS	
				Overrides	
				1.00	
WORKSHEET OVERRIDE VALUES					
112.00	Override of Ancillary service charges (line 12)				0112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0001 Component CCN: 14-5572	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/23/2021 8:29 am
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		264	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)		264	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		765	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)		765	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)		765	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		501	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)		264	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)		66	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)		198	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)		198	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		198	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)		198	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)		198	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		171	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)		27	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0001 Component CCN: 14-5572	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/23/2021 8:29 am
		Title XVIII	Skilled Nursing Facility	PPS
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/23/2021 8:29 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		9,810,383		5,078,482	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	02/04/2021	40,102	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	10/05/2020	42,120		0	3.50
3.51		02/04/2021	380,626		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)		-422,746		40,102	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)		9,387,637		5,118,584	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		506,954		139,210	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		9,894,591		5,257,794	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0001

Period:

Worksheet E-1

Component CCN: 14-5572

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
11/23/2021 8:29 am

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		506,280		171	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)		506,280		171	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		10,458		27	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		516,738		198	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part II Date/Time Prepared: 11/23/2021 8:29 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0001 Component CCN:14-5572	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VI Date/Time Prepared: 11/23/2021 8:29 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		545,445	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		10,459	3.00
4.00	Subtotal (sum of lines 1 through 3)		555,904	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		39,166	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)		516,738	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
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		516,738	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		506,280	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)		10,458	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: 14-0001

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

Worksheet G

Date/Time Prepared:
11/23/2021 8:29 am

	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	6,558,575	0	0	0	1.00
2.00 Temporary investments	16,512,850	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	35,303,671	0	0	0	4.00
5.00 Other receivable	3,944,149	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-22,315,000	0	0	0	6.00
7.00 Inventory	2,124,075	0	0	0	7.00
8.00 Prepaid expenses	1,344,714	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	43,473,034	0	0	0	11.00
FIXED ASSETS					
12.00 Land	3,314,743	0	0	0	12.00
13.00 Land improvements	2,936,925	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	98,945,580	0	0	0	15.00
16.00 Accumulated depreciation	-71,687,252	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	1,086,480	0	0	0	19.00
20.00 Accumulated depreciation	0	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	37,492,907	0	0	0	23.00
24.00 Accumulated depreciation	0	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	13,805,905	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	85,895,288	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	116,601,985	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	2,403,348	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	119,005,333	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	248,373,655	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	9,385,904	0	0	0	37.00
38.00 Salaries, wages, and fees payable	4,910,672	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	4,802,476	0	0	0	43.00
44.00 Other current liabilities	1,426,778	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	20,525,830	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	57,146,617	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	6,696,271	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	63,842,888	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	84,368,718	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	164,004,937	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	164,004,937	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	248,373,655	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0001

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

Worksheet G-1

Date/Time Prepared:
11/23/2021 8:29 am

		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		133,650,393		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		28,664,351				2.00
3.00	Total (sum of line 1 and line 2)		162,314,744		0		3.00
4.00	CHANGE IN BENEFICIAL INTEREST IN PER	1,964,960		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)		1,964,960		0		10.00
11.00	Subtotal (line 3 plus line 10)		164,279,704		0		11.00
12.00	CHANGE IN TEMPORARILY RESTRICTED NET	274,766		0		0	12.00
13.00	ROUNDING	1		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)		274,767		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		164,004,937		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	CHANGE IN BENEFICIAL INTEREST IN PER		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	CHANGE IN TEMPORARILY RESTRICTED NET		0				12.00
13.00	ROUNDING		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: 14-0001

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/23/2021 8:29 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	12,392,506		12,392,506	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	1,723,251		1,723,251	7.00
8.00	NURSING FACILITY	585,674		585,674	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	14,701,431		14,701,431	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,355,458		3,355,458	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)	3,355,458		3,355,458	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	18,056,889		18,056,889	17.00
18.00	Ancillary services	37,684,208	142,621,553	180,305,761	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	19,163,039	19,163,039	20.00
20.01	ELMWOOD RHC	0	488,445	488,445	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				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	DURABLE MEDICAL EQUIP - RENTED	0	4,609,284	4,609,284	27.00
27.01	PROFESSIONAL FEES	1,634,676	7,797,676	9,432,352	27.01
27.02	LAB GROSS UP	0	0	0	27.02
27.03	SCHOOL OF NURSING	0	481,179	481,179	27.03
27.04	DIETARY	0	535,920	535,920	27.04
27.05	NON-RHC	0	73,519	73,519	27.05
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	57,375,773	175,770,615	233,146,388	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		95,396,164		29.00
30.00	PROVISION FOR BAD DEBTS	10,479,797			30.00
31.00	LAB GROSS UP	268,555			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)		10,748,352		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)		106,144,516		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0001

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

Worksheet G-3

Date/Time Prepared:
11/23/2021 8:29 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	233,146,388	1.00
2.00	Less contractual allowances and discounts on patients' accounts	139,246,113	2.00
3.00	Net patient revenues (line 1 minus line 2)	93,900,275	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	106,144,516	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-12,244,241	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,289,929	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	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	14,569	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	1,042,471	24.00
24.01	340B RETAIL PHARMACY	4,669,932	24.01
24.02	CHANGE IN FV OF INTEREST RATE SWAP	1,402,023	24.02
24.03	UNREALIZED GAIN ON INVESTMENTS	22,668,384	24.03
24.50	COVID-19 PHE Funding	9,958,968	24.50
25.00	Total other income (sum of lines 6-24)	41,046,276	25.00
26.00	Total (line 5 plus line 25)	28,802,035	26.00
27.00	CHANGE IN FV OF INTERST RATE SWAP	0	27.00
27.01	LOSS ON DISPOSAL	137,684	27.01
27.02	UNREALIZED LOSS ON INVESTMENTS	0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	137,684	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	28,664,351	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0001	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Prepared: 11/23/2021 8:29 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		441,765	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		17,317	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		18.49	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		459,082	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0001

Period:

Worksheet M-1

Component CCN: 14-3493

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 8:29 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	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	435,599	0	435,599	0	435,599
2.00	Physician Assistant	346,881	0	346,881	0	346,881
3.00	Nurse Practitioner	1,136,605	0	1,136,605	-320,550	816,055
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	1,898,092	0	1,898,092	-105,390	1,792,702
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	110,842	0	110,842	0	110,842
10.00	Subtotal (sum of lines 1 through 9)	3,928,019	0	3,928,019	-425,940	3,502,079
11.00	Physician Services Under Agreement	0	9,335,502	9,335,502	911,605	10,247,107
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	9,335,502	9,335,502	911,605	10,247,107
15.00	Medical Supplies	0	159,442	159,442	0	159,442
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	49,696	49,696	0	49,696
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	209,138	209,138	0	209,138
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,928,019	9,544,640	13,472,659	485,665	13,958,324
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	15,550	15,550	0	15,550
30.00	Administrative Costs	1,546,250	95,461	1,641,711	-489,524	1,152,187
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,546,250	111,011	1,657,261	-489,524	1,167,737
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,474,269	9,655,651	15,129,920	-3,859	15,126,061

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0001

Period:

Worksheet M-1

Component CCN: 14-3493

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 8:29 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	435,599	1.00
2.00	Physician Assistant	0	346,881	2.00
3.00	Nurse Practitioner	0	816,055	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	1,792,702	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	110,842	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,502,079	10.00
11.00	Physician Services Under Agreement	0	10,247,107	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	10,247,107	14.00
15.00	Medical Supplies	0	159,442	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	49,696	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	209,138	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	13,958,324	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	0	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	15,550	29.00
30.00	Administrative Costs	-10,453	1,141,734	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-10,453	1,157,284	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-10,453	15,115,608	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0001

Period:

Worksheet M-1

Component CCN: 14-8603

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 8:29 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	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	0	0	0	0	0
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	0	0	0	0	0
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	200,588	200,588
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	200,588	200,588
11.00	Physician Services Under Agreement	0	0	0	233,679	233,679
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	233,679	233,679
15.00	Medical Supplies	0	0	0	0	0
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	0	0	434,267	434,267
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	130,193	130,193
30.00	Administrative Costs	0	0	0	159,397	159,397
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	289,590	289,590
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	0	0	723,857	723,857

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0001

Period:

Worksheet M-1

Component CCN: 14-8603

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 8:29 am

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	200,588	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	200,588	10.00
11.00	Physician Services Under Agreement	0	233,679	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	233,679	14.00
15.00	Medical Supplies	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	434,267	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	0	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	130,193	29.00
30.00	Administrative Costs	0	159,397	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	289,590	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	723,857	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0001

Period:

Worksheet M-2

Component CCN: 14-3493

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 8:29 am

		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	15.07	54,963	4,200	63,294	1.00
2.00	Physician Assistant	2.09	5,068	2,100	4,389	2.00
3.00	Nurse Practitioner	8.06	20,600	2,100	16,926	3.00
4.00	Subtotal (sum of lines 1 through 3)	25.22	80,631		84,609	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.50	197		197	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)	25.72	80,828		84,806	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)				13,958,324	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				13,958,324	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				1,157,284	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				8,622,229	15.00
16.00	Total overhead (sum of lines 14 and 15)				9,779,513	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				9,779,513	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				9,779,513	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				23,737,837	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0001

Period:

Worksheet M-2

Component CCN: 14-8603

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 8:29 am

				RHC II		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	0.56	2,554	4,200	2,352		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.38	1,672	2,100	798		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.94	4,226		3,150	4,226	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.94	4,226			4,226	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)					434,267	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					434,267	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					289,590	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					442,777	15.00
16.00	Total overhead (sum of lines 14 and 15)					732,367	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					732,367	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					732,367	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,166,634	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-0001 Component CCN:14-3493	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/23/2021 8:29 am	
		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)			23,737,837	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			671,039	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			23,066,798	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			84,806	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)			84,806	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			271.99	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)	84.70	248.91	252.39	8.00
9.00	Rate for Program covered visits (see instructions)	271.99	271.99	252.39	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	8,472	3,854	4,033	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	2,304,299	1,048,249	1,017,889	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	16	15	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	4,352	3,786	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	4,352	3,786	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	4,378,575		16.00
16.01	Total program charges (see instructions)(from contractor's records)		2,521,090		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		198,204		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		344,235		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.)		3,029,445		16.04
16.05	Total program cost (see instructions)	0	3,373,680		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		247,534		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		415,040		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		3,373,680		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		153,893		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		3,527,573		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		3,527,573		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		3,043,364		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)		484,209		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0001 Component CCN: 14-8603	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/23/2021 8:29 am	
		Title XVIII	RHC II	Cost	
			1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,166,634	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			46,247	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,120,387	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,226	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			4,226	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			265.12	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)	84.70	309.42	313.75	8.00
9.00	Rate for Program covered visits (see instructions)	265.12	265.12	265.12	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	0	0	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	0	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.)		0	0	16.04
16.05	Total program cost (see instructions)	0	0	0	16.05
17.00	Primary payer amounts		0	0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		0	0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		9,628	0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		9,628	0	22.00
23.00	Allowable bad debts (see instructions)		0	0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	0	25.99
26.00	Net reimbursable amount (see instructions)		9,628	0	26.00
26.01	Sequestration adjustment (see instructions)		0	0	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	0	26.02
27.00	Interim payments		0	0	27.00
28.00	Tentative settlement (for contractor use only)		0	0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		9,628	0	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0001

Period:

Worksheet M-4

Component CCN: 14-3493

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 8:29 am

		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)	3,502,079	3,502,079	3,502,079	3,502,079	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000941	0.001853	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	3,295	6,489	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	322,812	61,986	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	326,107	68,475	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	13,958,324	13,958,324	13,958,324	13,958,324	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	9,779,513	9,779,513	9,779,513	9,779,513	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.023363	0.004906	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	228,479	47,978	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	554,586	116,453	0	0	10.00
11.00	Total number of injections/infusions (from your records)	1,865	3,670	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	297.37	31.73	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	417	942	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)	124,003	29,890	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)		671,039			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)		153,893			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0001

Period:

Worksheet M-4

Component CCN: 14-8603

From 07/01/2020

Date/Time Prepared:

To 06/30/2021

11/23/2021 8:29 am

		Title XVIII		RHC II	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	200,588	200,588	200,588	200,588	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000459	0.001870	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	92	375	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	12,002	4,746	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	12,094	5,121	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	434,267	434,267	434,267	434,267	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	732,367	732,367	732,367	732,367	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.027849	0.011792	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	20,396	8,636	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	32,490	13,757	0	0	10.00
11.00	Total number of injections/infusions (from your records)	69	281	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	470.87	48.96	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	14	62	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)	6,592	3,036	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)		46,247			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)		9,628			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0001 Component CCN: 14-3493	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/23/2021 8:29 am	
			RHC I	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			2,971,946	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			02/04/2021	71,418	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)			71,418	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			3,043,364	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			484,209	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			3,527,573	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00