

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: 14-0019	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/23/2021 12:39 pm
--	-----------------------	---	--

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/23/2021	Time: 12:39 pm
	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 HSHS GOOD SHEPHERD HOSPITAL (14-0019) 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	5,204	26,609	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
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		-49,090		0	10.00
200.00	Total	0	5,204	-22,481	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: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/23/2021 12:39 pm

1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 200 SOUTH CEDAR	PO Box:								1.00
2.00	City: SHELBYVILLE	State: IL		Zip Code: 62565-1899		County: SHELBY				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	HSHS GOOD SHEPHERD HOSPITAL	140019	99914	1	07/01/1966	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	HSHS GOOD SHEPHERD HOSPITAL SWING BE	14U019	99914		04/13/1993	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									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	HSHS GOOD SHEPHERD HOSPITAL RHC	143446	99914		06/05/1998	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2020	06/30/2021			20.00
21.00	Type of Control (see instructions)					2				21.00
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				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.				3	N				23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0019		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 12:39 pm			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	171	0	0	0	102	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	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N					N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N					N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N					N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N							56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N							57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N							58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N							59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0019		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 12:39 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/23/2021 12:39 pm

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0019	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 12:39 pm	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0019		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 12:39 pm	
				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.			Y		108.00	
				Physical	Occupational	Speech	Respiratory
				1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N	N	N
						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		
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	
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:			29,449	238	142,116	118.01
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N		118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			N		121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.			N		122.00	
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: 14-0019		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 12:39 pm	
		1.00	2.00				
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		148005		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: HOSPITAL SISTERS HEALTH SYSTEM	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 00131		141.00	
142.00	Street: 4936 LAVERNA ROAD	PO Box:				142.00	
143.00	City: SPRINGFIELD	State: IL		Zip Code: 62707		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	N		N		N	
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		CBSA		FTE/Campus	
		3.00		4.00		5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00				169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0019	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 12:39 pm
			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: 14-0019		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part II Date/Time Prepared: 11/23/2021 12:39 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
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				
		1.00	2.00				
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				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing 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	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/01/2021	Y	11/01/2021		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/23/2021 12:39 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		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.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA		RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314.236.5210		PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0019	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/23/2021 12:39 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGING DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/23/2021 12:39 pm

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	30	10,950	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)		30	10,950	0.00	0	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)		30	10,950	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						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		30				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: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/23/2021 12:39 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	320	171	725		1.00
2.00	HMO and other (see instructions)	0	102			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	352	0	426		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	99		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	672	171	1,250		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)	672	171	1,250	0.00	101.65
15.00	CAH visits	0	0	0		14.00
16.00	SUBPROVIDER - IPF					15.00
17.00	SUBPROVIDER - IRF					16.00
18.00	SUBPROVIDER					17.00
19.00	SKILLED NURSING FACILITY					18.00
20.00	NURSING FACILITY					19.00
21.00	OTHER LONG TERM CARE					20.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	21.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					22.00
24.00	HOSPICE					23.00
24.10	HOSPICE (non-distinct part)			0		24.00
25.00	CMHC - CMHC					24.10
26.00	RURAL HEALTH CLINIC	5,891	361	17,742	0.00	25.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.00
27.00	Total (sum of lines 14-26)				0.00	8.00
28.00	Observation Bed Days		12	152		0.00
29.00	Ambulance Trips	0				109.65
30.00	Employee discount days (see instruction)			0		28.00
31.00	Employee discount days - IRF			0		29.00
32.00	Labor & delivery days (see instructions)	0	0	0		30.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		31.00
33.00	LTCH non-covered days	0				32.00
33.01	LTCH site neutral days and discharges	0				32.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/23/2021 12:39 pm

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	112	44	236	1.00
2.00 HMO and other (see instructions)			0	34		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	112	44	236	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						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 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: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/23/2021 12:39 pm

		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	4,004,564	0	4,004,564	213,606.55	18.75	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		0	0	0	0.00	0.00	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		85,728	0	85,728	2,307.00	37.16	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		6,411	26,770	33,181	2,169.50	15.29	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		646,180	0	646,180	9,302.37	69.46	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		665,368	0	665,368	15,989.09	41.61	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)		386,400	0	386,400			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		3,696	0	3,696			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		6,537	0	6,537			23.00
24.00	Wage-related costs (RHC/FQHC)		1,678	0	1,678			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		271,583	0	271,583			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/23/2021 12:39 pm

		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	12,555	0	12,555	409.55	30.66	26.00
27.00	Administrative & General	5.00	369,355	-49,017	320,338	28,152.64	11.38	27.00
28.00	Administrative & General under contract (see inst.)		68,654	0	68,654	357.21	192.20	28.00
29.00	Maintenance & Repairs	6.00	167	0	167	19.00	8.79	29.00
30.00	Operation of Plant	7.00	217,245	0	217,245	13,434.46	16.17	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	149,257	-26,770	122,487	12,119.78	10.11	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	136,266	-75,732	60,534	5,530.55	10.95	34.00
35.00	Dietary under contract (see instructions)		44,581	0	44,581	774.00	57.60	35.00
36.00	Cafeteria	11.00	0	75,732	75,732	6,919.13	10.95	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,669	0	2,669	28.50	93.65	38.00
39.00	Central Services and Supply	14.00	30,246	0	30,246	2,361.72	12.81	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	2,751	0	2,751	137.87	19.95	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: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part III
Date/Time Prepared:
11/23/2021 12:39 pm

	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)	4,032,071	0	4,032,071	212,430.76	18.98	1.00
2.00	Excluded area salaries (see instructions)	6,411	26,770	33,181	2,169.50	15.29	2.00
3.00	Subtotal salaries (line 1 minus line 2)	4,025,660	-26,770	3,998,890	210,261.26	19.02	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,311,548	0	1,311,548	25,291.46	51.86	4.00
5.00	Subtotal wage-related costs (see inst.)	657,983	0	657,983	0.00	16.45	5.00
6.00	Total (sum of lines 3 thru 5)	5,995,191	-26,770	5,968,421	235,552.72	25.34	6.00
7.00	Total overhead cost (see instructions)	1,033,746	-75,787	957,959	70,244.41	13.64	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0019	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 11/23/2021 12:39 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		8,780	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)		26,539	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		127,213	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)		0	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)		3,859	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		66,721	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		89,668	17.00
18.00	Medicare Taxes - Employers Portion Only		58,066	18.00
19.00	Unemployment Insurance		0	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))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		17,465	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		398,311	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part V
Date/Time Prepared:
11/23/2021 12:39 pm

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	646,180	398,311	1.00
2.00	Hospital	646,180	398,311	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			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

Health Financial Systems		HSHS GOOD SHEPHERD HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0019 Component CCN: 14-3446		Period: From 07/01/2020 To 06/30/2021 Worksheet S-8 Date/Time Prepared: 11/23/2021 12:39 pm		
		RHC I		Cost		
		1.00				
1.00	Clinic Address and Identification	200 SOUTH CEDAR STREET				1.00
	Street	City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	SHELBYVILLE		IL 62565	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		
4.00	Source of Federal Funds					4.00
5.00	Community Health Center (Section 330(d), PHS Act)					5.00
6.00	Migrant Health Center (Section 329(d), PHS Act)					6.00
7.00	Health Services for the Homeless (Section 340(d), PHS Act)					7.00
8.00	Appalachian Regional Commission					8.00
9.00	Look-Alikes					9.00
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	
		1.00	2.00	3.00	4.00	
		1.00		2.00		
11.00	Facility hours of operations (1)					11.00
11.00	CLINIC	08:00	19:00	08:00		
		1.00		2.00		
12.00	Have you received an approval for an exception to the productivity standard?	N		0	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	XVIII	XIX	
		1.00	2.00	3.00	4.00	
		1.00		2.00		
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	SHELBY		2.00		
		Tuesday	Wednesday	Thursday		
		to	from	to	from	
		6.00	7.00	8.00	9.00	
		1.00		2.00		
11.00	Facility hours of operations (1)					11.00
11.00	CLINIC	19:00	08:00	19:00	08:00	
		1.00		2.00		

Health Financial Systems		HSHS GOOD SHEPHERD HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0019	Period: From 07/01/2020	Worksheet S-8
			Component CCN: 14-3446	To 06/30/2021	Date/Time Prepared: 11/23/2021 12:39 pm
			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	08:00	17:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0019	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/23/2021 12:39 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.334965	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		140,606	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		1,186,329	6.00
7.00	Medicaid cost (line 1 times line 6)		397,379	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		256,773	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		256,773	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	141,967	116,588	258,555
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	47,554	116,588	164,142
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)	47,554	116,588	164,142
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,006,615	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		70,518	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		108,490	27.01
28.00	Non-Medicare bad debt expense (see instructions)		898,125	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		338,812	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		502,954	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		759,727	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0019

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

Worksheet A

Date/Time Prepared:
11/23/2021 12:39 pm

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		430,288		160,322	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	573,766	573,766	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,555	701,081	-929	712,707	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	369,355	3,042,421	-85,828	3,325,948	5.00
6.00	00600	MAINTENANCE & REPAIRS	167	0	601	768	6.00
7.00	00700	OPERATION OF PLANT	217,245	531,812	-84,797	664,260	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	44,102	0	44,102	8.00
9.00	00900	HOUSEKEEPING	149,257	6,403	-26,770	128,890	9.00
10.00	01000	DIETARY	136,266	195,277	-184,366	147,177	10.00
11.00	01100	CAFETERIA	0	0	184,261	184,261	11.00
13.00	01300	NURSING ADMINISTRATION	2,669	758	3,427	3,427	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	30,246	98,811	817	129,874	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,751	28,324	0	31,075	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	631,267	242,099	-6,245	867,121	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	151,510	277,148	-165,338	263,320	50.00
53.00	05300	ANESTHESIOLOGY	24,570	51,537	0	76,107	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	444,072	327,590	-28,259	743,403	54.00
60.00	06000	LABORATORY	246,348	772,572	-10,709	1,008,211	60.00
65.00	06500	RESPIRATORY THERAPY	153,342	63,496	-1,173	215,665	65.00
66.00	06600	PHYSICAL THERAPY	143,439	488,272	-502	631,209	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	23,031	23,031	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	178,586	586,883	43,886	809,355	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,156	0	1,156	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	85,728	2,510,349	-15,300	2,580,777	88.00
90.00	09000	CLINIC	139,367	13,678	0	153,045	90.00
91.00	09100	EMERGENCY	870,340	1,124,535	40,252	2,035,127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	9,073	256	-1,075	8,254	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	-401	401	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		105,510	-105,510	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,998,153	11,643,957	-119,752	15,522,358	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	6,411	94,246	119,752	220,409	192.00
194.00	07950	FUND DEVELOPMENT	0	31,660	0	31,660	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	4,004,564	11,769,863	0	15,774,427	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0019

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

Worksheet A

Date/Time Prepared:
11/23/2021 12:39 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	168,726	329,048	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	180,936	754,702	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-516,470	196,237	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-954,164	2,371,784	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	768	6.00
7.00	00700	OPERATION OF PLANT	0	664,260	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	44,102	8.00
9.00	00900	HOUSEKEEPING	0	128,890	9.00
10.00	01000	DIETARY	-44,581	102,596	10.00
11.00	01100	CAFETERIA	-12,024	172,237	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,427	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	129,874	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	169,507	200,582	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-51,878	815,243	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	263,320	50.00
53.00	05300	ANESTHESIOLOGY	-49,197	26,910	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	743,403	54.00
60.00	06000	LABORATORY	0	1,008,211	60.00
65.00	06500	RESPIRATORY THERAPY	0	215,665	65.00
66.00	06600	PHYSICAL THERAPY	-553,424	77,785	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	23,031	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	809,355	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,156	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	222,103	2,802,880	88.00
90.00	09000	CLINIC	0	153,045	90.00
91.00	09100	EMERGENCY	-1,059,997	975,130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-28,566	-20,312	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,529,029	12,993,329	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	220,409	192.00
194.00	07950	FUND DEVELOPMENT	0	31,660	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,529,029	13,245,398	200.00

RECLASSIFICATIONS

Provider CCN: 14-0019

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

Worksheet A-6

Date/Time Prepared:
11/23/2021 12:39 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - MEDICAL CENTER RECLASS					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	26,770	0		1.00
	0		26,770	0		
	B - RHC SANITARY RECLASS					
1.00	RURAL HEALTH CLINIC	88.00	0	827		1.00
	TOTALS		0	827		
	C - TELEPHONE EXPENSE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,201		1.00
2.00	HOME HEALTH AGENCY	101.00	0	581		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
	TOTALS		0	20,782		
	E - RENTAL RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	211,572		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
	TOTALS		0	211,572		
	F - MEDICAL CENTER UTILITIES RECLASS					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	0	82,894		1.00
	0		0	82,894		
	G - PHYSICIAN BUILDING DEPR RECLASS					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	0	13,282		1.00
2.00		0.00	0	0		2.00
	0		0	13,282		
	H - DEPRECIATION EXPENSE RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	362,581		1.00
	0		0	362,581		
	J - CAFETERIA EXPENSE RECLASS					
1.00	CAFETERIA	11.00	75,732	108,529		1.00
	0		75,732	108,529		
	M - INTEREST EXPENSE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	105,510		1.00
	0		0	105,510		
	N - MEDICAL SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	23,031		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	817		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	23,848		
	O - PHARMACY RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	49,824		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
	TOTALS		0	49,824		
	R - COVID EXPENSE					
1.00	MAINTENANCE & REPAIRS	6.00	0	601		1.00
2.00	ADULTS & PEDIATRICS	30.00	1,379	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	23	0		3.00
4.00	RESPIRATORY THERAPY	65.00	1,251	0		4.00
5.00	EMERGENCY	91.00	46,364	0		5.00
7.00	PHYSICAL THERAPY		0	0		7.00
8.00	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0		8.00

RECLASSIFICATIONS

Provider CCN: 14-0019

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

Worksheet A-6

Date/Time Prepared:
11/23/2021 12:39 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
9.00	CLINIC		0	0	9.00
10.00	EMERGENCY		0	0	10.00
			49,017	601	
S - HOME HEALTH EXPENSE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	180	1.00
	TOTALS		0	180	
500.00	Grand Total: Increases		151,519	980,430	500.00

RECLASSIFICATIONS

Provider CCN: 14-0019

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

Worksheet A-6

Date/Time Prepared:
11/23/2021 12:39 pm

	Decreases						11/23/2021 12:39 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MEDICAL CENTER RECLASS						
1.00	HOUSEKEEPING	9.00	26,770	0	0		1.00
	0		26,770	0			
	B - RHC SANITARY RECLASS						
1.00	OPERATION OF PLANT	7.00	0	827	0		1.00
	TOTALS		0	827			
	C - TELEPHONE EXPENSE RECLASS						
1.00	OPERATION OF PLANT	7.00	0	490	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	610	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	490	0		3.00
4.00	LABORATORY	60.00	0	450	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	891	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	484	0		6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	801	0		7.00
8.00	RURAL HEALTH CLINIC	88.00	0	16,061	0		8.00
9.00	EMERGENCY	91.00	0	496	0		9.00
10.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	9	0		10.00
	TOTALS		0	20,782			
	E - RENTAL RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	52,085	10		1.00
2.00	OPERATION OF PLANT	7.00	0	586	0		2.00
3.00	DIETARY	10.00	0	105	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	3,881	0		4.00
5.00	OPERATING ROOM	50.00	0	137,628	0		5.00
6.00	LABORATORY	60.00	0	10,259	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	800	0		7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,096	0		8.00
9.00	RURAL HEALTH CLINIC	88.00	0	66	0		9.00
10.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	1,066	0		10.00
	TOTALS		0	211,572			
	F - MEDICAL CENTER UTILITIES RECLASS						
1.00	OPERATION OF PLANT	7.00	0	82,894	0		1.00
	0		0	82,894			
	G - PHYSICIAN BUILDING DEPR RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	12,895	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	387	9		2.00
	0		0	13,282			
	H - DEPRECIATION EXPENSE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	362,581	9		1.00
	0		0	362,581			
	J - CAFETERIA EXPENSE RECLASS						
1.00	DIETARY	10.00	75,732	108,529	0		1.00
	0		75,732	108,529			
	M - INTEREST EXPENSE RECLASS						
1.00	INTEREST EXPENSE	113.00	0	105,510	11		1.00
	0		0	105,510			
	N - MEDICAL SUPPLIES RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,506	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	56	0		2.00
3.00	OPERATING ROOM	50.00	0	18,015	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	714	0		4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	41	0		5.00
6.00	EMERGENCY	91.00	0	516	0		6.00
	TOTALS		0	23,848			
	O - PHARMACY RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	929	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	3,077	0		2.00
3.00	OPERATING ROOM	50.00	0	9,695	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	27,792	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	19	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	18	0		6.00
7.00	EMERGENCY	91.00	0	5,100	0		7.00
8.00	PHYSICIANS PRIVATE OFFICES	192.00	0	3,194	0		8.00
	TOTALS		0	49,824			
	R - COVID EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	49,017	601	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00

RECLASSIFICATIONS

Provider CCN: 14-0019

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

Worksheet A-6

Date/Time Prepared:
11/23/2021 12:39 pm

	Decreases				Wkst. A-7 Ref.			
	Cost Center	Line #	Salary	Other				
	6.00	7.00	8.00	9.00	10.00			
	0		49,017	601				
	S - HOME HEALTH EXPENSE RECLASS							
1.00	HOME HEALTH AGENCY	101.00	0	180	0		1.00	
	TOTALS		0	180				
500.00	Grand Total: Decreases		151,519	980,430			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/23/2021 12:39 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	617,631	0	0	0	0	1.00	
2.00	Land Improvements	282,931	0	0	0	282,931	2.00	
3.00	Buildings and Fixtures	15,508,433	1,443,443	0	1,443,443	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	4,842,107	13,516	0	13,516	0	5.00	
6.00	Movable Equipment	11,275,088	512,998	0	512,998	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	32,526,190	1,969,957	0	1,969,957	282,931	8.00	
9.00	Reconciling Items	0	483,674	0	483,674	0	9.00	
10.00	Total (line 8 minus line 9)	32,526,190	1,486,283	0	1,486,283	282,931	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	617,631	0				1.00	
2.00	Land Improvements	0	0				2.00	
3.00	Buildings and Fixtures	16,951,876	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	4,855,623	0				5.00	
6.00	Movable Equipment	11,788,086	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	34,213,216	0				8.00	
9.00	Reconciling Items	483,674	0				9.00	
10.00	Total (line 8 minus line 9)	33,729,542	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/23/2021 12:39 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	430,076	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)	430,076	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	212	430,288				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	212	430,288				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/23/2021 12:39 pm

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	17,569,507	0	17,569,507	0.513530	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16,643,709	0	16,643,709	0.486470	0	2.00
3.00	Total (sum of lines 1-2)	34,213,216	0	34,213,216	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related 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	0	328,836	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	543,130	211,572	2.00
3.00	Total (sum of lines 1-2)	0	0	0	871,966	211,572	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related 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	0	0	0	212	329,048	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	754,702	2.00
3.00	Total (sum of lines 1-2)	0	0	0	212	1,083,750	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0019

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

Worksheet A-8

Date/Time Prepared:
11/23/2021 12:39 pm

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	-105,510	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)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-9,453	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)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,265,413			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	196,347			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-12,024	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	-78	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** 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: 14-0019

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

Worksheet A-8

Date/Time Prepared:
11/23/2021 12:39 pm

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 #		
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	MISCELLANEOUS INCOME	B	-9,042	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	RENTAL REVENUE	B	-169,942	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	BANK CHARGES	B	28,897	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-3,878	ADULTS & PEDIATRICS	30.00	0	33.03
33.04	HME SALES	B	-28,566	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.04
33.05	PROMOTIONAL ITEMS	A	-35,912	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	LOBBYING DUES	A	-8,845	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	FRA TAX	A	-499,607	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	REAL ESTATE TAXES	A	-10,951	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	EMPLOYEE HEALTH INSURANCE	B	-447,261	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	PENSION	A	9,018	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	VMG VALUATION DEPRECIATION ADJUSTMEN	A	274,236	CAP REL COSTS-BLDG & FIXT	1.00	9	33.11
33.12	VMG VALUATION DEPRECIATION ADJUSTMEN	A	180,936	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.12
33.13	SPORTSCARE SALARY	A	-66,013	PHYSICAL THERAPY	66.00	0	33.13
33.14	SPORTSCARE OTHER	A	-487,411	PHYSICAL THERAPY	66.00	0	33.14
33.15	SPORTSCARE BENEFITS	A	-11,557	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	ICAHN GRANT	A	-47,000	ADMINISTRATIVE & GENERAL	5.00	9	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,529,029				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-0019

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

Worksheet A-8-1

Date/Time Prepared:
11/23/2021 12:39 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	CONTRACTED SERVICES - ISC/SS	578,589	538,884	1.00
2.00	88.00	RURAL HEALTH CLINIC	HSHS MEDICAL GROUP	222,103	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES	26,237	81,477	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HSHS RELATED PARTY ACTIVITY	20,888	20,888	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SBO FEES - A&G	264,248	550,000	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	SBO FEES - MEDICAL RECORDS	169,585	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	HSHS IL ALLOCATIONS - DIVISI	118,306	0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	HSHS IL ALLOCATIONS - LIBRAR	4,559	5,489	4.04
4.05	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF-INS PREMIUMS	884,400	895,830	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,288,915	2,092,568	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-0019

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

Worksheet A-8-1

Date/Time Prepared:
11/23/2021 12:39 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	39,705	0		1.00
2.00	222,103	0		2.00
3.00	-55,240	0		3.00
4.00	0	0		4.00
4.01	-285,752	0		4.01
4.02	169,585	0		4.02
4.03	118,306	0		4.03
4.04	-930	0		4.04
4.05	-11,430	0		4.05
5.00	196,347			5.00

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

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0019

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

Worksheet A-8-2

Date/Time Prepared:
11/23/2021 12:39 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	48,000	48,000	0	0	0	1.00
2.00	91.00	EMERGENCY	1,059,997	1,059,997	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	49,197	49,197	0	0	0	3.00
4.00	10.00	DIETARY	44,581	44,581	0	0	0	4.00
5.00	5.00	ADMINISTRATIVE & GENERAL	61,798	61,798	0	0	0	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	1,840	1,840	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			1,265,413	1,265,413	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	10.00	DIETARY	0	0	0	0	0	4.00
5.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	48,000		1.00
2.00	91.00	EMERGENCY	0	0	0	1,059,997		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	49,197		3.00
4.00	10.00	DIETARY	0	0	0	44,581		4.00
5.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	61,798		5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	1,840		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,265,413		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/23/2021 12:39 pm

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	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	329,048	329,048			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	754,702	754,702			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	196,237	3,725	8,545	208,507	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,371,784	44,997	103,206	16,732	2,536,719
6.00	00600	MAINTENANCE & REPAIRS	768	7,924	18,174	9	26,875
7.00	00700	OPERATION OF PLANT	664,260	7,623	17,485	11,347	700,715
8.00	00800	LAUNDRY & LINEN SERVICE	44,102	6,660	15,275	0	66,037
9.00	00900	HOUSEKEEPING	128,890	3,164	7,257	6,398	145,709
10.00	01000	DIETARY	102,596	10,080	23,120	3,162	138,958
11.00	01100	CAFETERIA	172,237	3,535	8,109	3,956	187,837
13.00	01300	NURSING ADMINISTRATION	3,427	3,040	6,974	139	13,580
14.00	01400	CENTRAL SERVICES & SUPPLY	129,874	17,288	39,652	1,580	188,394
16.00	01600	MEDICAL RECORDS & LIBRARY	200,582	7,769	17,819	144	226,314
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	815,243	47,600	109,166	33,044	1,005,053
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	263,320	26,998	61,921	7,914	360,153
53.00	05300	ANESTHESIOLOGY	26,910	530	1,216	1,283	29,939
54.00	05400	RADIOLOGY-DIAGNOSTIC	743,403	23,329	53,508	23,196	843,436
60.00	06000	LABORATORY	1,008,211	9,223	21,154	12,867	1,051,455
65.00	06500	RESPIRATORY THERAPY	215,665	6,505	14,920	8,075	245,165
66.00	06600	PHYSICAL THERAPY	77,785	17,036	39,075	7,492	141,388
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,031	0	0	0	23,031
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	809,355	3,491	8,008	9,328	830,182
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	1,156	6,311	14,474	0	21,941
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,802,880	21,283	48,815	4,478	2,877,456
90.00	09000	CLINIC	153,045	34,197	78,433	7,279	272,954
91.00	09100	EMERGENCY	975,130	8,856	20,313	47,877	1,052,176
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-20,312	7,884	18,083	474	6,129
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,993,329	329,048	754,702	206,774	12,991,596
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS PRIVATE OFFICES	220,409	0	0	1,733	222,142
194.00	07950	FUND DEVELOPMENT	31,660	0	0	0	31,660
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	13,245,398	329,048	754,702	208,507	13,245,398

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/23/2021 12:39 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,536,719					5.00
6.00	00600	MAINTENANCE & REPAIRS	6,366	33,241				6.00
7.00	00700	OPERATION OF PLANT	165,988	930	867,633			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,643	813	21,823	104,316		8.00
9.00	00900	HOUSEKEEPING	34,516	386	10,369	0	190,980	9.00
10.00	01000	DIETARY	32,917	1,230	33,032	0	7,551	10.00
11.00	01100	CAFETERIA	44,496	431	11,585	0	2,648	11.00
13.00	01300	NURSING ADMINISTRATION	3,217	371	9,963	0	2,278	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	44,628	2,110	56,651	1,519	12,950	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	53,610	948	25,458	0	5,820	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	238,081	5,809	155,965	30,974	35,652	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	85,314	3,294	88,466	4,588	20,223	50.00
53.00	05300	ANESTHESIOLOGY	7,092	65	1,738	0	397	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	199,796	2,847	76,447	17,363	17,476	54.00
60.00	06000	LABORATORY	249,073	1,125	30,222	0	6,909	60.00
65.00	06500	RESPIRATORY THERAPY	58,076	794	21,316	0	4,873	65.00
66.00	06600	PHYSICAL THERAPY	33,493	2,079	55,825	14,991	12,762	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,456	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	196,657	426	11,440	0	2,615	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	5,197	770	20,679	0	4,727	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	681,627	2,597	69,742	949	15,943	88.00
90.00	09000	CLINIC	64,658	4,173	112,056	166	25,616	90.00
91.00	09100	EMERGENCY	249,244	1,081	29,021	33,766	6,634	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,452	962	25,835	0	5,906	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,476,597	33,241	867,633	104,316	190,980	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	52,622	0	0	0	0	192.00
194.00	07950	FUND DEVELOPMENT	7,500	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,536,719	33,241	867,633	104,316	190,980	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/23/2021 12:39 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	213,688					10.00
11.00	01100	CAFETERIA	0	246,997				11.00
13.00	01300	NURSING ADMINISTRATION	0	49	29,458			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,964	0	310,216		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	232	0	385	312,767	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	213,688	60,724	12,415	13,817	53,971	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	6,032	1,233	31,914	19,771	50.00
53.00	05300	ANESTHESIOLOGY	0	295	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,033	0	5,641	39,508	54.00
60.00	06000	LABORATORY	0	21,524	0	172,768	39,508	60.00
65.00	06500	RESPIRATORY THERAPY	0	20,599	0	26,785	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,154	0	3,219	29,640	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	4,606	0	6,447	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	490	19,771	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	3,872	792	8,951	80,958	88.00
90.00	09000	CLINIC	0	18,159	3,712	1,116	0	90.00
91.00	09100	EMERGENCY	0	55,300	11,306	31,206	29,640	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	3,812	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	213,688	243,355	29,458	302,739	312,767	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	3,642	0	768	0	192.00
194.00	07950	FUND DEVELOPMENT	0	0	0	6,709	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	213,688	246,997	29,458	310,216	312,767	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/23/2021 12:39 pm

Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	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
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,826,149	0	1,826,149	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	620,988	0	620,988	50.00
53.00	05300	ANESTHESIOLOGY	0	39,526	0	39,526	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,237,547	0	1,237,547	54.00
60.00	06000	LABORATORY	0	1,572,584	0	1,572,584	60.00
65.00	06500	RESPIRATORY THERAPY	0	377,608	0	377,608	65.00
66.00	06600	PHYSICAL THERAPY	0	302,551	0	302,551	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	28,487	0	28,487	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,052,373	0	1,052,373	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	73,575	0	73,575	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,742,887	0	3,742,887	88.00
90.00	09000	CLINIC	0	502,610	0	502,610	90.00
91.00	09100	EMERGENCY	0	1,499,374	0	1,499,374	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	44,096	0	44,096	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	12,920,355	0	12,920,355	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	279,174	0	279,174	192.00
194.00	07950	FUND DEVELOPMENT	0	45,869	0	45,869	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	13,245,398	0	13,245,398	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/23/2021 12:39 pm

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	3,725	8,545	12,270	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,801	44,997	103,206	173,004	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	7,924	18,174	26,098	6.00
7.00	00700	OPERATION OF PLANT	0	7,623	17,485	25,108	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,660	15,275	21,935	8.00
9.00	00900	HOUSEKEEPING	0	3,164	7,257	10,421	9.00
10.00	01000	DIETARY	0	10,080	23,120	33,200	10.00
11.00	01100	CAFETERIA	0	3,535	8,109	11,644	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,040	6,974	10,014	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,288	39,652	56,940	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,769	17,819	25,588	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	47,600	109,166	156,766	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	26,998	61,921	88,919	50.00
53.00	05300	ANESTHESIOLOGY	0	530	1,216	1,746	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,329	53,508	76,837	54.00
60.00	06000	LABORATORY	0	9,223	21,154	30,377	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,505	14,920	21,425	65.00
66.00	06600	PHYSICAL THERAPY	0	17,036	39,075	56,111	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	3,491	8,008	11,499	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	6,311	14,474	20,785	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	21,283	48,815	70,098	88.00
90.00	09000	CLINIC	0	34,197	78,433	112,630	90.00
91.00	09100	EMERGENCY	0	8,856	20,313	29,169	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	7,884	18,083	25,967	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,801	329,048	754,702	1,108,551	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	FUND DEVELOPMENT	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,801	329,048	754,702	1,108,551	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/23/2021 12:39 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	173,989					5.00
6.00	00600	MAINTENANCE & REPAIRS	437	26,536				6.00
7.00	00700	OPERATION OF PLANT	11,385	743	37,904			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,073	649	953	24,610		8.00
9.00	00900	HOUSEKEEPING	2,367	308	453	0	13,926	9.00
10.00	01000	DIETARY	2,258	982	1,443	0	551	10.00
11.00	01100	CAFETERIA	3,052	344	506	0	193	11.00
13.00	01300	NURSING ADMINISTRATION	221	296	435	0	166	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,061	1,684	2,475	358	944	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,677	757	1,112	0	424	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,329	4,636	6,814	7,307	2,598	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,851	2,630	3,865	1,082	1,475	50.00
53.00	05300	ANESTHESIOLOGY	486	52	76	0	29	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,703	2,273	3,340	4,096	1,274	54.00
60.00	06000	LABORATORY	17,083	898	1,320	0	504	60.00
65.00	06500	RESPIRATORY THERAPY	3,983	634	931	0	355	65.00
66.00	06600	PHYSICAL THERAPY	2,297	1,660	2,439	3,537	931	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	374	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	13,488	340	500	0	191	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	356	615	903	0	345	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	46,755	2,073	3,047	224	1,163	88.00
90.00	09000	CLINIC	4,435	3,331	4,895	39	1,868	90.00
91.00	09100	EMERGENCY	17,095	863	1,268	7,967	484	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	100	768	1,129	0	431	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	169,866	26,536	37,904	24,610	13,926	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	3,609	0	0	0	0	192.00
194.00	07950	FUND DEVELOPMENT	514	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	173,989	26,536	37,904	24,610	13,926	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/23/2021 12:39 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	38,620					10.00
11.00	01100	CAFETERIA	0	15,972				11.00
13.00	01300	NURSING ADMINISTRATION	0	3	11,143			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	256	0	65,811		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15	0	82	31,663	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	38,620	3,928	4,697	2,931	5,464	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	390	466	6,770	2,002	50.00
53.00	05300	ANESTHESIOLOGY	0	19	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,265	0	1,197	4,000	54.00
60.00	06000	LABORATORY	0	1,392	0	36,652	4,000	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,332	0	5,682	0	65.00
66.00	06600	PHYSICAL THERAPY	0	592	0	683	3,001	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	298	0	1,368	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	104	2,002	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	250	299	1,899	8,193	88.00
90.00	09000	CLINIC	0	1,174	1,404	237	0	90.00
91.00	09100	EMERGENCY	0	3,576	4,277	6,620	3,001	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	246	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,620	15,736	11,143	64,225	31,663	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	236	0	163	0	192.00
194.00	07950	FUND DEVELOPMENT	0	0	0	1,423	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,620	15,972	11,143	65,811	31,663	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/23/2021 12:39 pm

Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	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
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		252,035	0	252,035	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		113,916	0	113,916	50.00
53.00	05300	ANESTHESIOLOGY		2,484	0	2,484	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		110,350	0	110,350	54.00
60.00	06000	LABORATORY		92,983	0	92,983	60.00
65.00	06500	RESPIRATORY THERAPY		34,817	0	34,817	65.00
66.00	06600	PHYSICAL THERAPY		71,692	0	71,692	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		374	0	374	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		28,233	0	28,233	73.00
76.00	03950	OTHER ANCILLARY COSTS		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		25,110	0	25,110	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		134,265	0	134,265	88.00
90.00	09000	CLINIC		130,441	0	130,441	90.00
91.00	09100	EMERGENCY		77,135	0	77,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		28,669	0	28,669	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD		0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,102,504	0	1,102,504	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN		0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES		4,110	0	4,110	192.00
194.00	07950	FUND DEVELOPMENT		1,937	0	1,937	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,108,551	0	1,108,551	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0019

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

Worksheet B-1

Date/Time Prepared:
11/23/2021 12:39 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MOVABLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	74,457					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		74,457				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	843	843	3,992,009			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,182	10,182	320,338	-2,536,719	10,708,679	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,793	1,793	167	0	26,875	6.00
7.00	00700	OPERATION OF PLANT	1,725	1,725	217,245	0	700,715	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,507	1,507	0	0	66,037	8.00
9.00	00900	HOUSEKEEPING	716	716	122,487	0	145,709	9.00
10.00	01000	DIETARY	2,281	2,281	60,534	0	138,958	10.00
11.00	01100	CAFETERIA	800	800	75,732	0	187,837	11.00
13.00	01300	NURSING ADMINISTRATION	688	688	2,669	0	13,580	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,912	3,912	30,246	0	188,394	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,758	1,758	2,751	0	226,314	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,770	10,770	632,646	0	1,005,053	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,109	6,109	151,510	0	360,153	50.00
53.00	05300	ANESTHESIOLOGY	120	120	24,570	0	29,939	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,279	5,279	444,095	0	843,436	54.00
60.00	06000	LABORATORY	2,087	2,087	246,348	0	1,051,455	60.00
65.00	06500	RESPIRATORY THERAPY	1,472	1,472	154,593	0	245,165	65.00
66.00	06600	PHYSICAL THERAPY	3,855	3,855	143,439	0	141,388	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	23,031	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	790	790	178,586	0	830,182	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,428	1,428	0	0	21,941	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,816	4,816	85,728	0	2,877,456	88.00
90.00	09000	CLINIC	7,738	7,738	139,367	0	272,954	90.00
91.00	09100	EMERGENCY	2,004	2,004	916,704	0	1,052,176	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,784	1,784	9,073	0	6,129	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,457	74,457	3,958,828	-2,536,719	10,454,877	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	33,181	0	222,142	192.00
194.00	07950	FUND DEVELOPMENT	0	0	0	0	31,600	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	329,048	754,702	208,507		2,536,719	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.419302	10.136079	0.052231		0.236884	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,270		173,989	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003074		0.016247	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: 14-0019

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

Worksheet B-1

Date/Time Prepared:
11/23/2021 12:39 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	61,639					6.00
7.00	00700	OPERATION OF PLANT	1,725	59,914				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,507	1,507	48,911			8.00
9.00	00900	HOUSEKEEPING	716	716	0	57,691		9.00
10.00	01000	DIETARY	2,281	2,281	0	2,281	6,277	10.00
11.00	01100	CAFETERIA	800	800	0	800	0	11.00
13.00	01300	NURSING ADMINISTRATION	688	688	0	688	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,912	3,912	712	3,912	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,758	1,758	0	1,758	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,770	10,770	14,523	10,770	6,277	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,109	6,109	2,151	6,109	0	50.00
53.00	05300	ANESTHESIOLOGY	120	120	0	120	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,279	5,279	8,141	5,279	0	54.00
60.00	06000	LABORATORY	2,087	2,087	0	2,087	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,472	1,472	0	1,472	0	65.00
66.00	06600	PHYSICAL THERAPY	3,855	3,855	7,029	3,855	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	790	790	0	790	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,428	1,428	0	1,428	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,816	4,816	445	4,816	0	88.00
90.00	09000	CLINIC	7,738	7,738	78	7,738	0	90.00
91.00	09100	EMERGENCY	2,004	2,004	15,832	2,004	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,784	1,784	0	1,784	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	61,639	59,914	48,911	57,691	6,277	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	0	0	0	192.00
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	33,241	867,633	104,316	190,980	213,688	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.539285	14.481307	2.132772	3.310395	34.043014	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	26,536	37,904	24,610	13,926	38,620	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.430507	0.632640	0.503159	0.241389	6.152621	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: 14-0019

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

Worksheet B-1

Date/Time Prepared:
11/23/2021 12:39 pm

Cost Center Description			CAFETERIA (MAN HOURS)	NURSING ADMINISTRATIO N (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	14.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	147,162					11.00
13.00	01300	NURSING ADMINISTRATION	29	85,848				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,362	0	505,736			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	138	0	627	9,191		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	36,180	36,180	22,525	1,586	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,594	3,594	52,029	581	0	50.00
53.00	05300	ANESTHESIOLOGY	176	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,873	0	9,197	1,161	0	54.00
60.00	06000	LABORATORY	12,824	0	281,658	1,161	0	60.00
65.00	06500	RESPIRATORY THERAPY	12,273	0	43,667	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,454	0	5,248	871	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	2,744	0	10,511	0	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	799	581	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,307	2,307	14,593	2,379	0	88.00
90.00	09000	CLINIC	10,819	10,819	1,819	0	0	90.00
91.00	09100	EMERGENCY	32,948	32,948	50,874	871	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2,271	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	144,992	85,848	493,547	9,191	0	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	2,170	0	1,252	0	0	192.00
194.00	07950	FUND DEVELOPMENT	0	0	10,937	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	246,997	29,458	310,216	312,767	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.678402	0.343141	0.613395	34.029703	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,972	11,143	65,811	31,663	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.108533	0.129799	0.130129	3.445001	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 12:39 pm

			Title XVIII	Hospital	PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1,826,149		1,826,149	0	1,826,149 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	620,988		620,988	0	620,988 50.00
53.00	05300 ANESTHESIOLOGY	39,526		39,526	0	39,526 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,237,547		1,237,547	0	1,237,547 54.00
60.00	06000 LABORATORY	1,572,584		1,572,584	0	1,572,584 60.00
65.00	06500 RESPIRATORY THERAPY	377,608	0	377,608	0	377,608 65.00
66.00	06600 PHYSICAL THERAPY	302,551	0	302,551	0	302,551 66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28,487		28,487	0	28,487 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,052,373		1,052,373	0	1,052,373 73.00
76.00	03950 OTHER ANCILLARY COSTS	0		0	0	0 76.00
76.97	07697 CARDIAC REHABILITATION	73,575		73,575	0	73,575 76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	3,742,887		3,742,887	0	3,742,887 88.00
90.00	09000 CLINIC	502,610		502,610	0	502,610 90.00
91.00	09100 EMERGENCY	1,499,374		1,499,374	0	1,499,374 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	316,505		316,505		316,505 92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	44,096		44,096	0	44,096 96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0	0 97.00
101.00	10100 HOME HEALTH AGENCY	0		0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
200.00	Subtotal (see instructions)	13,236,860	0	13,236,860	0	13,236,860 200.00
201.00	Less Observation Beds	316,505		316,505		316,505 201.00
202.00	Total (see instructions)	12,920,355	0	12,920,355	0	12,920,355 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 12:39 pm

			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	1,958,417		1,958,417			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,485	2,033,028	2,036,513	0.304927	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	4,675	549,777	554,452	0.071288	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	296,575	11,156,103	11,452,678	0.108057	0.000000	54.00
60.00	06000	LABORATORY	574,689	7,791,560	8,366,249	0.187968	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	55,819	1,293,888	1,349,707	0.279770	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	382,018	2,828,891	3,210,909	0.094226	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	126,168	547,692	673,860	0.042274	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	315,774	1,390,826	1,706,600	0.616649	0.000000	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	7,384	7,384	9.964112	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,988,352	2,988,352			88.00
90.00	09000	CLINIC	1,760	307,515	309,275	1.625123	0.000000	90.00
91.00	09100	EMERGENCY	154,439	3,541,720	3,696,159	0.405657	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,835	254,883	261,718	1.209336	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	3,880,654	34,691,619	38,572,273			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,880,654	34,691,619	38,572,273			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 12:39 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.304927			50.00
53.00	05300	ANESTHESIOLOGY	0.071288			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.108057			54.00
60.00	06000	LABORATORY	0.187968			60.00
65.00	06500	RESPIRATORY THERAPY	0.279770			65.00
66.00	06600	PHYSICAL THERAPY	0.094226			66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.042274			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.616649			73.00
76.00	03950	OTHER ANCILLARY COSTS	0.000000			76.00
76.97	07697	CARDIAC REHABILITATION	9.964112			76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	1.625123			90.00
91.00	09100	EMERGENCY	0.405657			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.209336			92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000			97.00
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/23/2021 12:39 pm

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		252,035	0	252,035	877	287.38	30.00
200.00	Total (lines 30 through 199)		252,035		252,035	877		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		320	91,962				
200.00	Total (lines 30 through 199)		320	91,962				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0019	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Prepared: 11/23/2021 12:39 pm	
				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	113,916	2,036,513	0.055937	0	0
53.00	05300	ANESTHESIOLOGY	2,484	554,452	0.004480	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,350	11,452,678	0.009635	275,245	2,652
60.00	06000	LABORATORY	92,983	8,366,249	0.011114	378,141	4,203
65.00	06500	RESPIRATORY THERAPY	34,817	1,349,707	0.025796	50,175	1,294
66.00	06600	PHYSICAL THERAPY	71,692	3,210,909	0.022328	51,120	1,141
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	374	673,860	0.000555	63,806	35
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	28,233	1,706,600	0.016543	122,364	2,024
76.00	03950	OTHER ANCILLARY COSTS	0	0	0.000000	0	0
76.97	07697	CARDIAC REHABILITATION	25,110	7,384	3.400596	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	134,265	2,988,352	0.044929	0	0
90.00	09000	CLINIC	130,441	309,275	0.421764	789	333
91.00	09100	EMERGENCY	77,135	3,696,159	0.020869	111,987	2,337
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	43,682	261,718	0.166905	4,094	683
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	28,669	0	0.000000	0	0
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0
200.00		Total (lines 50 through 199)	894,151	36,613,856		1,057,721	14,702

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-0019		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/23/2021 12:39 pm		
					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	0	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	877	0.00	320	30.00			
200.00		Total (lines 30 through 199)	0	0	877		320	200.00			
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0							30.00	
200.00		Total (lines 30 through 199)	0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 12:39 pm

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	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	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	0	0	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0019

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

Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 12:39 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	2,036,513	0.000000 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	554,452	0.000000 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,452,678	0.000000 54.00
60.00	06000	LABORATORY	0	0	0	8,366,249	0.000000 60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,349,707	0.000000 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,210,909	0.000000 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	673,860	0.000000 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,706,600	0.000000 73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0.000000 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	7,384	0.000000 76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,988,352	0.000000 88.00
90.00	09000	CLINIC	0	0	0	309,275	0.000000 90.00
91.00	09100	EMERGENCY	0	0	0	3,696,159	0.000000 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	261,718	0.000000 92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000 96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0.000000 97.00
200.00		Total (lines 50 through 199)	0	0	0	36,613,856	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 12:39 pm

				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	0.000000	0	0	1,037,656	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	477,732	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	275,245	0	4,980,108	0	54.00	
60.00	06000	LABORATORY	0.000000	378,141	0	1,306,727	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	50,175	0	602,843	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	51,120	0	1,865	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	63,806	0	298,820	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	122,364	0	765,235	0	73.00	
76.00	03950	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	6,276	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
90.00	09000	CLINIC	0.000000	789	0	281,243	0	90.00	
91.00	09100	EMERGENCY	0.000000	111,987	0	1,427,135	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	4,094	0	133,521	0	92.00	
	OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00	
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00	
200.00		Total (lines 50 through 199)		1,057,721	0	11,319,161	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/23/2021 12:39 pm

			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	0.304927	1,037,656	0	0	316,409	50.00
53.00	05300	ANESTHESIOLOGY	0.071288	477,732	6,648	0	34,057	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.108057	4,980,108	0	0	538,136	54.00
60.00	06000	LABORATORY	0.187968	1,306,727	5,433	0	245,623	60.00
65.00	06500	RESPIRATORY THERAPY	0.279770	602,843	0	0	168,657	65.00
66.00	06600	PHYSICAL THERAPY	0.094226	1,865	0	0	176	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.042274	298,820	0	0	12,632	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	0.616649	765,235	0	124	471,881	73.00
76.00	03950	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	9.964112	6,276	0	0	62,535	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	1.625123	281,243	0	0	457,054	90.00
91.00	09100	EMERGENCY	0.405657	1,427,135	0	0	578,927	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.209336	133,521	0	0	161,472	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Subtotal (see instructions)		11,319,161	12,081	124	3,047,559	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		11,319,161	12,081	124	3,047,559	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN:14-0019		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/23/2021 12:39 pm		
				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
53.00	05300	ANESTHESIOLOGY	474	0						53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0						54.00
60.00	06000	LABORATORY	1,021	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	76						73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0						76.00
76.97	07697	CARDIAC REHABILITATION	0	0						76.97
OUTPATIENT SERVICE COST CENTERS										
88.00	08800	RURAL HEALTH CLINIC								88.00
90.00	09000	CLINIC	0	0						90.00
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
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0						97.00
200.00		Subtotal (see instructions)	1,495	76						200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0							201.00
202.00		Net Charges (line 200 - line 201)	1,495	76						202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0019
Component CCN: 14-U019

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

Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 12:39 pm

Cost Center Description			Title XVIII		Swing Beds - SNF		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	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	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	0	0	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN:14-0019
Component CCN:14-U019

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

Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 12:39 pm

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	2,036,513	0.000000 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	554,452	0.000000 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,452,678	0.000000 54.00
60.00	06000	LABORATORY	0	0	0	8,366,249	0.000000 60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,349,707	0.000000 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,210,909	0.000000 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	673,860	0.000000 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,706,600	0.000000 73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0.000000 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	7,384	0.000000 76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,988,352	0.000000 88.00
90.00	09000	CLINIC	0	0	0	309,275	0.000000 90.00
91.00	09100	EMERGENCY	0	0	0	3,696,159	0.000000 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	261,718	0.000000 92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000 96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0.000000 97.00
200.00		Total (lines 50 through 199)	0	0	0	36,613,856	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0019
Component CCN: 14-U019

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

Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 12:39 pm

Cost Center Description			Title XVIII		Swing Beds - SNF		PPS	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	954	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	4,675	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	21,330	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	89,613	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	5,644	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	202,349	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	32,076	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73,615	0	0	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	971	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	3,883	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
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Total (lines 50 through 199)		435,110	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0019	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/23/2021 12:39 pm
		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)		1,402	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		877	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)		725	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		213	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)		213	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		50	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)		49	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		320	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)		176	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)		176	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)		1,826,149	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)		1,826,149	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)		1,826,149	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)		2,082.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		666,326	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)		666,326	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0019

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

Worksheet D-1

Date/Time Prepared:
11/23/2021 12:39 pm

		Title XVIII			Hospital	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)					249,488	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					915,814	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)					91,962	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					14,702	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					106,664	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					809,150	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)					152	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,082.27	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					316,505	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0019

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

Worksheet D-1

Date/Time Prepared:
11/23/2021 12:39 pm

		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	252,035	1,826,149	0.138014	316,505	43,682	90.00
91.00 Nursing School cost	0	1,826,149	0.000000	316,505	0	91.00
92.00 Allied health cost	0	1,826,149	0.000000	316,505	0	92.00
93.00 All other Medical Education	0	1,826,149	0.000000	316,505	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0019	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/23/2021 12:39 pm	
		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		702,401		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.304927	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.071288	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.108057	275,245	29,742	54.00
60.00	06000 LABORATORY	0.187968	378,141	71,078	60.00
65.00	06500 RESPIRATORY THERAPY	0.279770	50,175	14,037	65.00
66.00	06600 PHYSICAL THERAPY	0.094226	51,120	4,817	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.042274	63,806	2,697	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.616649	122,364	75,456	73.00
76.00	03950 OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	9.964112	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	1.625123	789	1,282	90.00
91.00	09100 EMERGENCY	0.405657	111,987	45,428	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.209336	4,094	4,951	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,057,721	249,488	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1,057,721		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN:14-0019 Component CCN:14-U019	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/23/2021 12:39 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	PPS	
		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
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.304927	954	291	50.00
53.00	05300 ANESTHESIOLOGY	0.071288	4,675	333	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.108057	21,330	2,305	54.00
60.00	06000 LABORATORY	0.187968	89,613	16,844	60.00
65.00	06500 RESPIRATORY THERAPY	0.279770	5,644	1,579	65.00
66.00	06600 PHYSICAL THERAPY	0.094226	202,349	19,067	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.042274	32,076	1,356	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.616649	73,615	45,395	73.00
76.00	03950 OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	9.964112	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	1.625123	971	1,578	90.00
91.00	09100 EMERGENCY	0.405657	3,883	1,575	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.209336	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		435,110	90,323	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		435,110		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A
Date/Time Prepared:
11/23/2021 12:39 pm

		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)			109,430	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			476,661	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)			0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			0	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)			28.15	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)			4.10	30.00
31.00	Percentage of Medicaid patient days (see instructions)			37.66	31.00
32.00	Sum of lines 30 and 31			41.76	32.00
33.00	Allowable disproportionate share percentage (see instructions)			12.00	33.00
34.00	Disproportionate share adjustment (see instructions)			17,583	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0019	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/23/2021 12:39 pm	
		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)		0.000014187	0.000012693	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		118,470	105,225	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		29,779	78,703	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		108,482		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)		712,156		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))		763,903		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			763,903	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			44,194	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			0	53.00
54.00	Special add-on payments for new technologies			0	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).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			808,097	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			808,097	61.00
62.00	Deductibles billed to program beneficiaries			116,212	62.00
63.00	Coinsurance billed to program beneficiaries			0	63.00
64.00	Allowable bad debts (see instructions)			14,088	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			9,157	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			10,195	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			701,042	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)			0	70.93
70.94	HRR adjustment amount (see instructions)			0	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0019	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/23/2021 12:39 pm
		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	38,616	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	163,408	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)		903,066	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			71.03
72.00	Interim payments		897,862	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		5,204	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		80,211	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)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	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	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	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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/23/2021 12:39 pm

		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	109,430	0	109,430		109,430
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	476,661	0		476,661	476,661
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	0	0	0		0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0
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	0.1200	0.1200	0.1200	0.1200	
11.00	Disproportionate share adjustment (see instructions)	34.00	17,583	0	3,283	14,300	17,583
11.01	Uncompensated care payments	36.00	108,482	0	29,779	78,703	108,482
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	712,156	0	142,492	569,664	712,156
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	763,903	0	145,871	618,032	763,903
15.00	Total payment for inpatient operating costs (see instructions)	49.00	763,903	0	145,871	618,032	763,903

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/23/2021 12:39 pm

		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	44,194	0	8,594	35,600	44,194
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ acquisition 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	154,465	653,632	808,097
		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	44,194	0	8,594	35,600	44,194
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	0	0	0	0	0
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	44,194	0	8,594	35,600	44,194
		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				0.250000	0.250000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			38,616		38,616
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				163,408	163,408
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/23/2021 12:39 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	109,430	109,430		109,430	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	476,661		476,661	476,661	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
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		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	17,583	3,283	14,300	17,583	11.00
11.01	Uncompensated care payments	36.00	108,482	29,779	78,703	108,482	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	712,156	142,492	569,664	712,156	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	763,903	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	763,903	0	763,903	763,903	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	44,194	8,594	35,600	44,194	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			8,594	799,503	808,097	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/23/2021 12:39 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	44,194	8,594	35,600	44,194	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	44,194	8,594	35,600	44,194	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	38,616	38,616		38,616	28.00
29.00	Low volume adjustment on or after October 1	70.97	163,408		163,408	163,408	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0019	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/23/2021 12:39 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,571	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,047,559	2.00
3.00	OPPS payments		1,821,693	3.00
4.00	Outlier payment (see instructions)		10,854	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1,571	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		12,205	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)		12,205	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)		12,205	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		10,634	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		1,571	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)		1,832,547	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		1,330	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		374,360	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,458,428	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,458,428	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,458,428	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)		64,065	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		41,642	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		52,899	36.00
37.00	Subtotal (see instructions)		1,500,070	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)		1,500,070	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		1,473,461	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)		26,609	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)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/23/2021 12:39 pm

		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		917,078		1,492,193	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	02/08/2021	19,216	02/08/2021	18,732	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)		-19,216		-18,732	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)		897,862		1,473,461	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		5,204		26,609	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		903,066		1,500,070	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-0019
 Component CCN: 14-U019

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 11/23/2021 12:39 pm

		Title XVIII		Swing Beds - SNF		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		194,024		0	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)		194,024		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		194,024		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/23/2021 12:39 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-0019	Period: From 07/01/2020 To 06/30/2021	Worksheet E-2	
		Component CCN: 14-U019		Date/Time Prepared: 11/23/2021 12:39 pm	
		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		208,465	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		0	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		352	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		208,465	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		208,465	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		208,465	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		14,441	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		194,024	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		194,024	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		194,024	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)		0	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

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

Provider CCN: 14-0019

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

Worksheet G

Date/Time Prepared:
11/23/2021 12:39 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,700,650	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,406,584	0	0	0	4.00
5.00	Other receivable	325,103	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	266,056	0	0	0	7.00
8.00	Prepaid expenses	77,861	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	71,438	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,847,692	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,091,231	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	-498,055	0	0	0	14.00
15.00	Buildings	16,951,876	0	0	0	15.00
16.00	Accumulated depreciation	-12,040,818	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	4,855,623	0	0	0	19.00
20.00	Accumulated depreciation	-4,220,120	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	11,788,086	0	0	0	23.00
24.00	Accumulated depreciation	-10,360,019	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	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,567,804	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	16,923,777	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	16,923,777	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	30,339,273	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	297,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	743,726	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	331,363	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	1,179,413	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,551,502	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,550,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,209,792	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	8,759,792	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,311,294	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	19,027,979				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	19,027,979	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	30,339,273	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0019

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

Worksheet G-1

Date/Time Prepared:
11/23/2021 12:39 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		18,676,708		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,570,468				2.00
3.00	Total (sum of line 1 and line 2)		20,247,176		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		20,247,176		0		11.00
12.00	CHANGE IN NET ASSETS	1,219,197		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		1,219,197		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		19,027,979		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	CHANGE IN NET ASSETS		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0019

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/23/2021 12:39 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,139,864		1,139,864	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	669,768		669,768	5.00
6.00	Swing bed - NF	155,650		155,650	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,965,282		1,965,282	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,965,282		1,965,282	17.00
18.00	Ancillary services	1,764,240	28,078,840	29,843,080	18.00
19.00	Outpatient services	163,034	4,176,707	4,339,741	19.00
20.00	RURAL HEALTH CLINIC	0	3,006,178	3,006,178	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	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	PRO FEES	2,348	427,075	429,423	27.00
27.01	PHYSICIAN OFFICES	0	503,609	503,609	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,894,904	36,192,409	40,087,313	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		15,774,427		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		15,774,427		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0019

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

Worksheet G-3

Date/Time Prepared:
11/23/2021 12:39 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	40,087,313	1.00
2.00	Less contractual allowances and discounts on patients' accounts	26,313,847	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,773,466	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	15,774,427	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,000,961	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	83,738	6.00
7.00	Income from investments	2,517,654	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	9,453	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	12,024	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	-191	17.00
18.00	Revenue from sale of medical records and abstracts	78	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	169,942	22.00
23.00	Governmental appropriations	0	23.00
24.00	PRO FEES	0	24.00
24.01	MISC INC	14,973	24.01
24.50	COVID-19 PHE Funding	774,706	24.50
25.00	Total other income (sum of lines 6-24)	3,582,377	25.00
26.00	Total (line 5 plus line 25)	1,581,416	26.00
27.00	PENSION	10,948	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	10,948	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,570,468	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0019	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Prepared: 11/23/2021 12:39 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		44,194	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	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)		1.99	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)		44,194	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: 14-0019

Period:

Worksheet M-1

Component CCN: 14-3446

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 12:39 pm

		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	0	974,756	974,756	-23,678	951,078
2.00	Physician Assistant	0	141,532	141,532	-351	141,181
3.00	Nurse Practitioner	85,728	713,260	798,988	-4,121	794,867
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	213,167	213,167	0	213,167
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)	85,728	2,042,715	2,128,443	-28,150	2,100,293
11.00	Physician Services Under Agreement	0	0	0	0	0
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	0	0
15.00	Medical Supplies	0	25,357	25,357	0	25,357
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	25,357	25,357	0	25,357
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	85,728	2,068,072	2,153,800	-28,150	2,125,650
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	28,150	28,150
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	28,150	28,150
FACILITY OVERHEAD						
29.00	Facility Costs	0	21,085	21,085	-15,300	5,785
30.00	Administrative Costs	0	421,192	421,192	0	421,192
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	442,277	442,277	-15,300	426,977
32.00	Total facility costs (sum of lines 22, 28 and 31)	85,728	2,510,349	2,596,077	-15,300	2,580,777

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0019

Period:

Worksheet M-1

Component CCN: 14-3446

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 12:39 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	951,078	1.00
2.00	Physician Assistant	0	141,181	2.00
3.00	Nurse Practitioner	0	794,867	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	213,167	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	2,100,293	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	25,357	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	25,357	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,125,650	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	28,150	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	28,150	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	5,785	29.00
30.00	Administrative Costs	222,103	643,295	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	222,103	649,080	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	222,103	2,802,880	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0019

Period:

Worksheet M-2

Component CCN: 14-3446

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 12:39 pm

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	2.00	7,690	4,200	8,400		1.00
2.00	Physician Assistant	0.89	3,004	2,100	1,869		2.00
3.00	Nurse Practitioner	5.11	7,048	2,100	10,731		3.00
4.00	Subtotal (sum of lines 1 through 3)	8.00	17,742		21,000	21,000	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)	8.00	17,742			21,000	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,125,650	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					28,150	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,153,800	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.986930	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					649,080	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					940,007	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,589,087	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,589,087	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,568,318	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,693,968	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-0019 Component CCN:14-3446	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/23/2021 12:39 pm	
		Title XVIII	RHC I	Cost	
			1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,693,968	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			74,618	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			3,619,350	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			21,000	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)			21,000	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			172.35	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	199.83	8.00
9.00	Rate for Program covered visits (see instructions)	172.35	172.35	172.35	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	2,786	1,393	1,712	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	480,167	240,084	295,063	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	1,015,314		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,044,071		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		73,847		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		71,813		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.)		683,285		16.04
16.05	Total program cost (see instructions)	0	755,098		16.05
17.00	Primary payer amounts		120		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		89,395		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		176,166		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		754,978		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		47,362		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		802,340		22.00
23.00	Allowable bad debts (see instructions)		30,337		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		19,719		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		28,001		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)		822,059		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		871,149		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)		-49,090		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0019

Period:

Worksheet M-4

Component CCN: 14-3446

From 07/01/2020

Date/Time Prepared:

To 06/30/2021

11/23/2021 12:39 pm

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,100,293	2,100,293	2,100,293	2,100,293	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001143	0.003940	0.000022	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,401	8,275	46	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	16,501	15,715	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	18,902	23,990	46	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,125,650	2,125,650	2,125,650	2,125,650	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,568,318	1,568,318	1,568,318	1,568,318	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.008892	0.011286	0.000022	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	13,945	17,700	35	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	32,847	41,690	81	0	10.00
11.00	Total number of injections/infusions (from your records)	154	531	3	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	213.29	78.51	27.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	112	299	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)	23,888	23,474	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)		74,618			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)		47,362			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-0019 Component CCN:14-3446	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/23/2021 12:39 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		891,660	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			0	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		02/08/2021	20,511	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)		-20,511	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		871,149	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		0	6.01	
6.02	SETTLEMENT TO PROGRAM		49,090	6.02	
7.00	Total Medicare program liability (see instructions)		822,059	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00