

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0147	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/26/2022 11:09 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 5/26/2022	Time: 11:09 am
	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	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RICHLAND MEMORIAL HOSPITAL (14-0147) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

Cost Center Description	Title V	Title XVIII		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	-66,670	51,441	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	2,631	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		203,716		0	10.00
10.01 RURAL HEALTH CLINIC II	0		12,605		0	10.01
10.02 RURAL HEALTH CLINIC III	0		126,592		0	10.02
200.00 Total	0	-64,039	394,354	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: 14-0147		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 11:09 am			
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 800 EAST LOCUST			PO Box:		1.00						
2.00	City: OLNEY			State: IL		Zip Code: 62450-2958		County: RICHLAND			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			RICHLAND MEMORIAL HOSPITAL	140147	99914	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF			RICHLAND MEMORIAL HOSPITAL PSYCH	14S147	99914	4	07/01/1966	N	P	P	4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF			RICHLAND MEMORIAL HOSPITAL SWING BED	14U147	99914		11/13/2003	N	P	N	7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF			RICHLAND MEMORIAL HOSPITAL SNF	145580	99914		11/05/1987	N	P	N	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			RICHLAND MEMORIAL HOSPITAL WEST SALE	148548	99914		12/04/2015	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II			RICHLAND MEMORIAL HOSPITAL FAM PRAC	148586	99914		03/14/2018	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III			RICHLAND MEMORIAL HOSPITAL PRIMARY C	148584	99914		03/15/2018	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
17.10	Hospital-Based (CORF) I											17.10
17.20	Hospital-Based (OPT) I											17.20
17.30	Hospital-Based (OOT) I											17.30
17.40	Hospital-Based (OSP) I											17.40
18.00	Renal Dialysis											18.00
19.00	Other											19.00
								From:	To:			
								1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)							01/01/2021	12/31/2021		20.00	
21.00	Type of Control (see instructions)							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)						N	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0147		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 11:09 am	
		1.00	2.00	3.00			
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N		22.04	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N			23.00	
		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.	723	0	0	0	0	71
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	
		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.	01/01/2021		12/31/2021		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)	Y		Y		40.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0147	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 11:09 am		
			V 1.00	XVIII 2.00	XIX 3.00	
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
		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

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00	
			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
5/26/2022 11:09 am

	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	
					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.			Y		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)			N	N 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.			Y	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.01	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0147	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 11:09 am
		V 1.00	XIX 2.00	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
		Physical 1.00	Occupational 2.00	Speech 3.00
			Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	109.00
			1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	110.00
			1.00	
			2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		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.	2		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0147	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 11:09 am
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	181,204	0	0
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		
119.00	DO NOT USE THIS LINE			
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	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		
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		
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		
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.			
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.			
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.			
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.			
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.			
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.			
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.			
133.00	Removed and reserved			
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.			
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		
		1.00	2.00	3.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name:	Contractor's Name:	Contractor's Number:	
142.00	Street:	PO Box:		
143.00	City:	State:	Zip Code:	
144.00	Are provider based physicians' costs included in Worksheet A?		Y	
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.			
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		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0147		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 11:09 am	
		Part A 1.00	Part B 2.00	Title V 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	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
161.10	CORF		N	N	N	161.10	
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N	161.20	
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N	161.30	
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N	161.40	
						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 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					9.99	169.00
					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: 14-0147		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 11:09 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	03/30/2022	Y	03/30/2022
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	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0147

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		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				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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.				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.				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.				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.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	LUCAS	MORTON		41.00
42.00	Enter the employer/company name of the cost report preparer.	CARLE HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-902-6326	LUCAS.MORTON@CARLE.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

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		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.	DIRECTOR-FINANCE		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: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
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Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	39	14,235	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)		39	14,235	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		47	17,155	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	34	12,410		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	1	365			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		82				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

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Part I
Date/Time Prepared:
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Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,443	444	2,866		1.00
2.00	HMO and other (see instructions)	0	71			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	751	0	751		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,194	444	3,617		7.00
8.00	INTENSIVE CARE UNIT	395	91	787		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		188	326		13.00
14.00	Total (see instructions)	2,589	723	4,730	0.00	257.71
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY	0	0	5,721	0.00	15.98
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE	0	0	0	0.00	0.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00
26.00	RURAL HEALTH CLINIC	2,297	0	5,494	0.00	8.37
26.01	RURAL HEALTH CLINIC II	77	0	6,333	0.00	2.67
26.02	RURAL HEALTH CLINIC III	3,983	0	15,124	0.00	24.17
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	308.90
28.00	Observation Bed Days		0	1,267		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	1		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/26/2022 11:09 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	479	334	1,218	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	479	334	1,218	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RURAL HEALTH CLINIC III	0.00					26.02
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: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
5/26/2022 11:09 am

		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	30,040,246	-844,670	29,195,576	726,552.00	40.18	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		1,079,074	0	1,079,074	8,400.00	128.46	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		3,706,818	0	3,706,818	26,574.00	139.49	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		1,339,877	0	1,339,877	58,102.00	23.06	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	1,007,862	0	1,007,862	36,510.00	27.61	9.00
10.00	Excluded area salaries (see instructions)		5,741,185	-321,793	5,419,392	91,972.59	58.92	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	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		4,809,539	0	4,809,539	139,358.47	34.51	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,310,046	0	4,310,046			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		949,246	0	949,246			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		210,533	0	210,533			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		54,707	0	54,707			23.00
24.00	Wage-related costs (RHC/FQHC)		797,393	0	797,393			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,530,217	0	1,530,217			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: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
5/26/2022 11:09 am

		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
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	29,949	0	29,949	1,133.00	26.43	26.00
27.00	Administrative & General	5.00	2,001,726	-14,663	1,987,063	67,856.00	29.28	27.00
28.00	Administrative & General under contract (see inst.)		1	0	1	1.00	1.00	28.00
29.00	Maintenance & Repairs	6.00	903,721	0	903,721	34,084.00	26.51	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	311,418	0	311,418	14,133.00	22.03	31.00
32.00	Housekeeping	9.00	608,382	0	608,382	34,995.00	17.38	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	791,326	-596,133	195,193	39,882.00	4.89	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	591,692	591,692	31,467.70	18.80	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,247,498	0	1,247,498	29,690.00	42.02	38.00
39.00	Central Services and Supply	14.00	78,209	0	78,209	4,558.00	17.16	39.00
40.00	Pharmacy	15.00	1,001,480	0	1,001,480	39,518.00	25.34	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	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: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part III
Date/Time Prepared:
5/26/2022 11:09 am

	Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	23,914,478	-844,670	23,069,808	633,477.00	36.42	1.00
2.00	Excluded area salaries (see instructions)	6,749,047	-321,793	6,427,254	128,482.59	50.02	2.00
3.00	Subtotal salaries (line 1 minus line 2)	17,165,431	-522,877	16,642,554	504,994.41	32.96	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,809,539	0	4,809,539	139,358.47	34.51	4.00
5.00	Subtotal wage-related costs (see inst.)	5,840,263	0	5,840,263	0.00	35.09	5.00
6.00	Total (sum of lines 3 thru 5)	27,815,233	-522,877	27,292,356	644,352.88	42.36	6.00
7.00	Total overhead cost (see instructions)	6,973,710	-19,104	6,954,606	297,317.70	23.39	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0147	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prepared: 5/26/2022 11:09 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,533,775	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		2,769,094	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	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)		-81,940	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		84,023	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		136,730	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		1,818,878	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		2,511	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		48,454	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		6,311,525	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: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part V
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	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	0	0	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	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0147 Component CCN: 14-8548		Period: From 01/01/2021 To 12/31/2021		Worksheet S-8 Date/Time Prepared: 5/26/2022 11:09 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			100 SOUTH MAIN			1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County			WEST SALEM			ILLINOIS 62476		2.00
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N			0		10.00
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC			08:00			17:00		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.								13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County								2.00
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC			17:00			08:00		17:00

Health Financial Systems		RICHLAND MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0147	Period: From 01/01/2021	Worksheet S-8
			Component CCN: 14-8548	To 12/31/2021	Date/Time Prepared: 5/26/2022 11:09 am
			RHC I		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	17:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0147 Component CCN: 14-8586		Period: From 01/01/2021 To 12/31/2021		Worksheet S-8 Date/Time Prepared: 5/26/2022 11:09 am	
				RHC II		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			800 LOCUST ST			1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County			OLNEY IL 62450			2.00		
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)						4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						6.00		
7.00	Appalachian Regional Commission						7.00		
8.00	Look-Alikes						8.00		
9.00	OTHER (SPECIFY)						9.00		
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N			0		10.00
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC								11.00
				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.								13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County		4.00			
2.00	City, State, ZIP Code, County			RICHLAND					2.00
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC								11.00

Health Financial Systems		RICHLAND MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0147	Period: From 01/01/2021	Worksheet S-8
			Component CCN: 14-8586	To 12/31/2021	Date/Time Prepared: 5/26/2022 11:09 am
			RHC II		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0147 Component CCN: 14-8584		Period: From 01/01/2021 To 12/31/2021		Worksheet S-8 Date/Time Prepared: 5/26/2022 11:09 am	
				RHC III		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				800 LOCUST ST				1.00
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				OLNEY IL 62450				2.00
								1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
								1.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC								11.00
								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.								13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				RICHLAND				2.00
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC								11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0147 Component CCN: 14-8584		Period: From 01/01/2021 To 12/31/2021	Worksheet S-8 Date/Time Prepared: 5/26/2022 11:09 am
					RHC III	Cost
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC					11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet S-10

Date/Time Prepared:
5/26/2022 11:09 am

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.269650	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		5,139,694	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			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		48,962,628	6.00
7.00	Medicaid cost (line 1 times line 6)		13,202,773	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)		8,063,079	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)		8,063,079	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,180,411	807,838	1,988,249
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	318,298	807,838	1,126,136
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)	318,298	807,838	1,126,136
			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)		2,697,438	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		247,286	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		380,440	27.01
28.00	Non-Medicare bad debt expense (see instructions)		2,316,998	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		757,933	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,884,069	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		9,947,148	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet A

Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		772,362	772,362	288,052	1,060,414	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	29,949	160,285	190,234	0	190,234	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,001,726	15,399,126	17,400,852	-287,685	17,113,167	5.00
6.00	00600	MAINTENANCE & REPAIRS	903,721	840,243	1,743,964	0	1,743,964	6.00
7.00	00700	OPERATION OF PLANT	0	622,350	622,350	0	622,350	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	311,418	205,915	517,333	0	517,333	8.00
9.00	00900	HOUSEKEEPING	608,382	321,688	930,070	0	930,070	9.00
10.00	01000	DIETARY	791,326	634,764	1,426,090	-1,066,319	359,771	10.00
11.00	01100	CAFETERIA	0	0	0	1,066,319	1,066,319	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,247,498	512,216	1,759,714	0	1,759,714	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,209	227,547	305,756	-104,857	200,899	14.00
15.00	01500	PHARMACY	1,001,480	2,887,506	3,888,986	-2,216,866	1,672,120	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,839	4,839	0	4,839	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,338,686	943,175	3,281,861	-240,649	3,041,212	30.00
31.00	03100	INTENSIVE CARE UNIT	561,658	202,202	763,860	-4,010	759,850	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	248,600	102,353	350,953	0	350,953	43.00
44.00	04400	SKILLED NURSING FACILITY	1,007,862	336,261	1,344,123	0	1,344,123	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	749,307	1,545,288	2,294,595	-808,096	1,486,499	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	227,148	227,148	52.00
53.00	05300	ANESTHESIOLOGY	1,100,680	299,858	1,400,538	-22,369	1,378,169	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	754,040	593,930	1,347,970	0	1,347,970	54.00
56.00	05600	RADIOISOTOPE	103,757	242,408	346,165	0	346,165	56.00
57.00	05700	CT SCAN	148,471	215,289	363,760	0	363,760	57.00
58.00	05800	MRI	73,522	141,180	214,702	0	214,702	58.00
60.00	06000	LABORATORY	1,060,268	1,685,739	2,746,007	0	2,746,007	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	463,019	216,838	679,857	0	679,857	65.00
66.00	06600	PHYSICAL THERAPY	1,635,021	533,016	2,168,037	0	2,168,037	66.00
68.00	06800	SPEECH PATHOLOGY	189,630	216,857	406,487	0	406,487	68.00
69.00	06900	ELECTROCARDIOLOGY	0	25,990	25,990	0	25,990	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	947,175	947,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	134,441	134,441	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,216,866	2,216,866	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	935,162	269,018	1,204,180	104,098	1,308,278	88.00
88.01	08801	RURAL HEALTH CLINIC II	881,649	185,224	1,066,873	33,227	1,100,100	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,823,428	865,386	2,688,814	300,514	2,989,328	88.02
91.00	09100	EMERGENCY	3,250,592	531,216	3,781,808	-128,783	3,653,025	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	46	61	107	-107	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	16	244	260	-260	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,299,123	31,740,374	56,039,497	437,839	56,477,336	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,735,705	1,170,533	6,906,238	-437,839	6,468,399	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	0	0	0	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet A

Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.03	07951	CONTRACTED RETAIL RX	5,418	543,762	549,180	0	549,180	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	30,040,246	33,454,669	63,494,915	0	63,494,915	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet A

Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-21,032	1,039,382	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	765,199	955,433	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-7,237,543	9,875,624	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,743,964	6.00
7.00	00700	OPERATION OF PLANT	659,042	1,281,392	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-121,966	395,367	8.00
9.00	00900	HOUSEKEEPING	0	930,070	9.00
10.00	01000	DIETARY	0	359,771	10.00
11.00	01100	CAFETERIA	-188,238	878,081	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	787,319	2,547,033	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	251,097	451,996	14.00
15.00	01500	PHARMACY	0	1,672,120	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	550,103	554,942	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	3,041,212	30.00
31.00	03100	INTENSIVE CARE UNIT	0	759,850	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
43.00	04300	NURSERY	0	350,953	43.00
44.00	04400	SKILLED NURSING FACILITY	-40,087	1,304,036	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,486,499	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	227,148	52.00
53.00	05300	ANESTHESIOLOGY	-1,100,679	277,490	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,347,970	54.00
56.00	05600	RADIOISOTOPE	0	346,165	56.00
57.00	05700	CT SCAN	0	363,760	57.00
58.00	05800	MRI	0	214,702	58.00
60.00	06000	LABORATORY	0	2,746,007	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	679,857	65.00
66.00	06600	PHYSICAL THERAPY	0	2,168,037	66.00
68.00	06800	SPEECH PATHOLOGY	-314	406,173	68.00
69.00	06900	ELECTROCARDIOLOGY	0	25,990	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	947,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	134,441	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,216,866	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	76,212	1,384,490	88.00
88.01	08801	RURAL HEALTH CLINIC II	92,218	1,192,318	88.01
88.02	08802	RURAL HEALTH CLINIC III	161,707	3,151,035	88.02
91.00	09100	EMERGENCY	-2,286,110	1,366,915	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,653,072	48,824,264	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-2,762,619	3,705,780	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	194.00
194.01	07952	MEMORY DISORDER	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	0	549,180	194.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet A

Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
200.00	TOTAL (SUM OF LINES 118 through 199)	-10,415,691	53,079,224		200.00

RECLASSIFICATIONS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-6

Date/Time Prepared:
5/26/2022 11:09 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - RECLASS CAFETERIA					1.00
	CAFETERIA	11.00	591,692	474,627		
	0		591,692	474,627		
1.00	B - INTEREST EXPENSE					1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	243,052		
	0		0	243,052		
1.00	C - OTHER CAPITAL RELATED					1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	45,000		
	0	0.00	0	0		
2.00	0		0	45,000	2.00	
1.00	D - RECLASS IMPLANTS					1.00
	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	134,441		
	0		0	134,441		
1.00	E - RECLASS MEDICAL SUPPLIES					1.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	947,175		
	0	0.00	0	0		
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	0.00	0	0	6.00	
1.00	F - RECLASS DRUGS					1.00
	DRUGS CHARGED TO PATIENTS	73.00	0	2,216,866		
	0		0	2,216,866		
1.00	G - LABOR AND DELIVERY					1.00
	DELIVERY ROOM & LABOR ROOM	52.00	170,743	56,405		
	TOTALS		170,743	56,405		
1.00	H - CONTRACT LABOR					1.00
	ADMINISTRATIVE & GENERAL	5.00	0	14,725		
	DIETARY	10.00	0	4,441		
2.00	ADULTS & PEDIATRICS	30.00	0	6,370	2.00	
3.00	EMERGENCY	91.00	0	819,134	3.00	
4.00	TOTALS		0	844,670	4.00	
1.00	I - PHYSICIAN PRACTICE MANAGEMENT					1.00
	RURAL HEALTH CLINIC	88.00	76,493	27,605		
	RURAL HEALTH CLINIC II	88.01	24,416	8,811		
2.00	RURAL HEALTH CLINIC III	88.02	220,822	79,692	2.00	
3.00	TOTALS		321,731	116,108	3.00	
1.00	J - TERMINATED PROVIDERS					1.00
	ADMINISTRATIVE & GENERAL	5.00	62	305		
	0	0.00	0	0		
2.00	TOTALS		62	305	2.00	
500.00	Grand Total: Increases		1,084,228	5,078,649	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-6

Date/Time Prepared:
5/26/2022 11:09 am

	Decreases						
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA						
1.00	DIETARY	10.00	591,692	474,627	0		1.00
	0		591,692	474,627			
	B - INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	243,052	11		1.00
	0		0	243,052			
	C - OTHER CAPITAL RELATED						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	45,000	12		1.00
2.00		0.00	0	0	13		2.00
	0		0	45,000			
	D - RECLASS IMPLANTS						
1.00	OPERATING ROOM	50.00	0	134,441	0		1.00
	0		0	134,441			
	E - RECLASS MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	104,857	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	13,501	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	4,010	0		3.00
4.00	OPERATING ROOM	50.00	0	673,655	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	22,369	0		5.00
6.00	EMERGENCY	91.00	0	128,783	0		6.00
	0		0	947,175			
	F - RECLASS DRUGS						
1.00	PHARMACY	15.00	0	2,216,866	0		1.00
	0		0	2,216,866			
	G - LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	170,743	56,405	0		1.00
	TOTALS		170,743	56,405			
	H - CONTRACT LABOR						
1.00	ADMINISTRATIVE & GENERAL	5.00	14,725	0	0		1.00
2.00	DIETARY	10.00	4,441	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	6,370	0	0		3.00
4.00	EMERGENCY	91.00	819,134	0	0		4.00
	TOTALS		844,670	0			
	I - PHYSICIAN PRACTICE MANAGEMENT						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	321,731	116,108	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		321,731	116,108			
	J - TERMINATED PROVIDERS						
1.00	HOSPICE	116.00	16	244	0		1.00
2.00	HOME HEALTH AGENCY	101.00	46	61	0		2.00
	TOTALS		62	305			
500.00	Grand Total: Decreases		1,928,898	4,233,979			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part I
Date/Time Prepared:
5/26/2022 11:09 am

		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	1,005,119	0	0	0	0	1.00	
2.00	Land Improvements	549,876	57,940	0	57,940	0	2.00	
3.00	Buildings and Fixtures	23,506,177	0	0	0	1,721,294	3.00	
4.00	Building Improvements	9,558,256	0	0	0	0	4.00	
5.00	Fixed Equipment	2,355,173	0	0	0	0	5.00	
6.00	Movable Equipment	25,318,569	2,489,033	0	2,489,033	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	62,293,170	2,546,973	0	2,546,973	1,721,294	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	62,293,170	2,546,973	0	2,546,973	1,721,294	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,005,119	0					1.00
2.00	Land Improvements	607,816	0					2.00
3.00	Buildings and Fixtures	21,784,883	0					3.00
4.00	Building Improvements	9,558,256	0					4.00
5.00	Fixed Equipment	2,355,173	0					5.00
6.00	Movable Equipment	27,807,602	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	63,118,849	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	63,118,849	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part II
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	772,362	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)	772,362	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	772,362				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	772,362				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part III
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	36,974,601	0	36,974,601	0.593558	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	25,318,569	0	25,318,569	0.406442	0	2.00
3.00	Total (sum of lines 1-2)	62,293,170	0	62,293,170	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	772,362	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)	0	0	0	772,362	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	222,020	45,000	0	0	1,039,382	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	222,020	45,000	0	0	1,039,382	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-8

Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-21,032	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	0	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	0	ADMINISTRATIVE & GENERAL	5.00	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	-2,300,835			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	-552,263			0	12.00
13.00	Laundry and linen service	B	-121,966	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-155,614	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	B	-40	MEDICAL RECORDS & LIBRARY	16.00	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	0	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	B	-12,059	CAFETERIA	11.00	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: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-8

Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		2.00	3.00	4.00	5.00		
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	SPECIAL FUNCTIONS	B	-20,565	CAFETERIA	11.00	0	33.00
34.00	GUEST ROOM	B	0	ADULTS & PEDIATRICS	30.00	0	34.00
35.00	MISC REVENUE	B	-63,867	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	MISC REVENUE	B	-314	SPEECH PATHOLOGY	68.00	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.00
38.00	PHYSICIAN RECRUITMENT	A	-164,618	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	CRNA SALARIES	A	-1,100,679	ANESTHESIOLOGY	53.00	0	39.00
41.00	CRNA BENEFITS	A	-210,532	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
42.00	LOBBYING DUES	A	-1	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	DONATIONS	A	-226,587	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.00
46.00	ADVERTISING	A	-232,127	ADMINISTRATIVE & GENERAL	5.00	0	46.00
47.00	PROVIDER TAX ASSESSMENT	A	-2,429,526	ADMINISTRATIVE & GENERAL	5.00	0	47.00
49.02	PROVIDER TAX ASSESSMENT	A	-40,087	SKILLED NURSING FACILITY	44.00	0	49.02
49.03	NON ALLOWABLE EXP	A	-360	ADMINISTRATIVE & GENERAL	5.00	0	49.03
49.04	HOSPITALIST SALARIES	A	-2,367,673	PHYSICIANS' PRIVATE OFFICES	192.00	0	49.04
49.05	HOSPITALIST BENEFITS	A	-394,946	PHYSICIANS' PRIVATE OFFICES	192.00	0	49.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,415,691				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: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-8-1

Date/Time Prepared:
5/26/2022 11:09 am

	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	HO ALLOCATION	975,731	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HO ALLOCATION	6,445,256	10,550,988	2.00
3.00	7.00	OPERATION OF PLANT	HO ALLOCATION	659,042	0	3.00
3.01	14.00	CENTRAL SERVICES & SUPPLY	HO ALLOCATION	251,097	0	3.01
3.02	16.00	MEDICAL RECORDS & LIBRARY	HO ALLOCATION	550,143	0	3.02
4.00	88.00	RURAL HEALTH CLINIC	HO ALLOCATION	76,212	0	4.00
4.01	88.01	RURAL HEALTH CLINIC II	HO ALLOCATION	92,218	0	4.01
4.02	88.02	RURAL HEALTH CLINIC III	HO ALLOCATION	161,707	0	4.02
4.03	13.00	NURSING ADMINISTRATION	HO ALLOCATION	787,319	0	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
4.06	0.00			0	0	4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,998,725	10,550,988	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	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00	B	THE CARLE FOUND	100.00	SYSTEM	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: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-8-1

Date/Time Prepared:
5/26/2022 11:09 am

	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	975,731	0		1.00
2.00	-4,105,732	0		2.00
3.00	659,042	0		3.00
3.01	251,097	0		3.01
3.02	550,143	0		3.02
4.00	76,212	0		4.00
4.01	92,218	0		4.01
4.02	161,707	0		4.02
4.03	787,319	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
5.00	-552,263			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: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-8-2

Date/Time Prepared:
5/26/2022 11:09 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	14,725	14,725	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	2,286,110	2,286,110	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		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			2,300,835	2,300,835	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	14,725		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	91.00	EMERGENCY	0	0	0	2,286,110		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,300,835		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,039,382	1,039,382			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	955,433	3,206	0	958,639	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,875,624	97,261	0	65,313	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,743,964	13,270	0	29,704	6.00
7.00	00700	OPERATION OF PLANT	1,281,392	46,153	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	395,367	19,033	0	10,236	8.00
9.00	00900	HOUSEKEEPING	930,070	2,164	0	19,997	9.00
10.00	01000	DIETARY	359,771	39,928	0	6,416	10.00
11.00	01100	CAFETERIA	878,081	11,328	0	19,448	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,547,033	39,604	0	41,004	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	451,996	28,054	0	2,571	14.00
15.00	01500	PHARMACY	1,672,120	15,172	0	32,918	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	554,942	11,789	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,041,212	153,690	0	71,049	30.00
31.00	03100	INTENSIVE CARE UNIT	759,850	36,916	0	18,461	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
43.00	04300	NURSERY	350,953	5,217	0	8,171	43.00
44.00	04400	SKILLED NURSING FACILITY	1,304,036	18,908	0	33,127	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,486,499	61,518	0	24,629	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	227,148	4,693	0	5,612	52.00
53.00	05300	ANESTHESIOLOGY	277,490	0	0	36,178	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,347,970	44,473	0	24,785	54.00
56.00	05600	RADIOISOTOPE	346,165	5,126	0	3,410	56.00
57.00	05700	CT SCAN	363,760	3,947	0	4,880	57.00
58.00	05800	MRI	214,702	0	0	2,417	58.00
60.00	06000	LABORATORY	2,746,007	41,563	0	34,850	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	679,857	4,784	0	15,219	65.00
66.00	06600	PHYSICAL THERAPY	2,168,037	30,372	0	53,742	66.00
68.00	06800	SPEECH PATHOLOGY	406,173	1,179	0	6,233	68.00
69.00	06900	ELECTROCARDIOLOGY	25,990	2,050	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	947,175	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	134,441	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,216,866	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,384,490	17,085	0	33,252	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,192,318	17,791	0	29,781	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,151,035	93,969	0	67,192	88.02
91.00	09100	EMERGENCY	1,366,915	19,432	0	79,920	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,824,264	889,675	0	780,515	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,705,780	148,864	0	177,946	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.01	07952	MEMORY DISORDER	0	843	0	0	843	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	549,180	0	0	178	549,358	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	53,079,224	1,039,382	0	958,639	53,079,224	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			ADMINISTRATIVE E & 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	10,038,198					5.00
6.00	00600	MAINTENANCE & REPAIRS	416,757	2,203,695				6.00
7.00	00700	OPERATION OF PLANT	309,615	109,877	1,747,037			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	99,035	45,312	37,807	606,790		8.00
9.00	00900	HOUSEKEEPING	222,083	5,152	4,299	40,220	1,223,985	9.00
10.00	01000	DIETARY	94,716	95,058	79,314	1,980	0	10.00
11.00	01100	CAFETERIA	211,967	26,968	22,501	7,448	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	612,829	94,285	78,669	0	28,006	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	112,559	66,788	55,727	8,794	17,398	14.00
15.00	01500	PHARMACY	401,194	36,119	30,137	0	7,638	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	132,175	28,066	23,418	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	761,698	365,900	305,298	157,386	323,551	30.00
31.00	03100	INTENSIVE CARE UNIT	190,131	87,885	73,330	55,885	57,073	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	84,973	12,419	10,363	38,336	35,644	43.00
44.00	04400	SKILLED NURSING FACILITY	316,268	45,014	37,559	168,986	108,629	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	366,779	146,457	122,201	59,287	81,472	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	55,380	11,172	9,322	4,804	9,972	52.00
53.00	05300	ANESTHESIOLOGY	73,155	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	330,532	105,877	88,342	11,181	56,012	54.00
56.00	05600	RADIOISOTOPE	82,725	12,203	10,182	1,253	13,366	56.00
57.00	05700	CT SCAN	86,896	9,396	7,840	0	14,003	57.00
58.00	05800	MRI	50,637	0	0	0	0	58.00
60.00	06000	LABORATORY	658,256	98,949	82,561	1,892	35,644	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	163,224	11,389	9,503	0	5,092	65.00
66.00	06600	PHYSICAL THERAPY	525,256	72,307	60,331	9,751	150,001	66.00
68.00	06800	SPEECH PATHOLOGY	96,458	2,807	2,342	0	17,822	68.00
69.00	06900	ELECTROCARDIOLOGY	6,540	4,881	4,073	0	19,095	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	220,904	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,355	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	517,026	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	334,636	40,675	33,938	624	49,435	88.00
88.01	08801	RURAL HEALTH CLINIC II	289,172	42,356	35,341	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	772,484	223,713	186,661	0	0	88.02
91.00	09100	EMERGENCY	341,969	46,261	38,599	38,963	124,754	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,969,384	1,847,286	1,449,658	606,790	1,154,607	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	940,494	354,402	295,705	0	69,378	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	197	2,007	1,674	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	128,123	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
202.00		TOTAL (sum lines 118 through 201)	10,038,198	2,203,695	1,747,037	606,790	1,223,985	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	677,183					10.00
11.00	01100	CAFETERIA	0	1,177,741				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	76,766	0	3,518,196		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,027	0	0	760,914	14.00
15.00	01500	PHARMACY	0	53,913	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,028	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	218,620	50,067	0	1,156,453	0	30.00
31.00	03100	INTENSIVE CARE UNIT	34,889	6,119	0	253,287	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	120,516	0	43.00
44.00	04400	SKILLED NURSING FACILITY	417,014	26,997	0	529,420	5,399	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	50,907	0	183,201	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,660	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	30,362	0	0	16,292	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	29,219	0	0	4,436	54.00
56.00	05600	RADIOISOTOPE	0	6,593	0	0	1,748	56.00
57.00	05700	CT SCAN	0	12,473	0	0	18,071	57.00
58.00	05800	MRI	0	8,716	0	0	3,064	58.00
60.00	06000	LABORATORY	0	51,376	0	0	293,440	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	12,622	0	0	6,783	65.00
66.00	06600	PHYSICAL THERAPY	0	170,461	0	0	6,210	66.00
68.00	06800	SPEECH PATHOLOGY	0	18,046	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	279	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	298,786	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	39,161	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	92,629	0	216,308	3,559	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	65,137	0	195,741	649	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	151,472	0	454,480	4,452	88.02
91.00	09100	EMERGENCY	0	6,422	0	408,790	34,300	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	677,183	938,352	0	3,518,196	736,629	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	239,389	0	0	24,285	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	0	0	0	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	677,183	1,177,741	0	3,518,196	760,914	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	2,249,211					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	751,418				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING PROGRAM	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	157,038	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	11,820	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	11,820	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	15,197	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	234,713	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,066	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,574	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	37,149	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,209,923	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,879	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,334	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	8,740	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	79,363	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,229,876	570,740	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,335	180,678	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	0	0	0	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
		15.00	16.00	17.00	19.00	20.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,249,211	751,418	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet B
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	6,761,962	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	1,585,646	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	678,412	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	3,026,554	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,817,663	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	339,829	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	433,477	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,061,401	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	482,771	0	56.00
57.00	05700	CT SCAN	0	0	0	521,266	0	57.00
58.00	05800	MRI	0	0	0	279,536	0	58.00
60.00	06000	LABORATORY	0	0	0	4,081,687	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	908,473	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,246,468	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	551,060	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	62,908	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,466,865	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	204,957	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,943,815	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,211,510	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,874,620	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	5,114,198	0	88.02
91.00	09100	EMERGENCY	0	0	0	2,585,688	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE			0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	46,240,766	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	6,156,256	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALA RY & FRINGES APPRV	SERVICES-OTHE R PRGM COSTS APPRV				
			21.00	22.00				
194.01	07952	MEMORY DISORDER	0	0	0	4,721	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	0	0	0	677,481	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	53,079,224	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING PROGRAM	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
88.02	08802	RURAL HEALTH CLINIC III	88.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	OTHER NONREIMBURSABLE	194.00
194.01	07952	MEMORY DISORDER	194.01
194.02	07953	ASSISTED LIVING	194.02
194.03	07951	CONTRACTED RETAIL RX	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,206	0	3,206	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,057	97,261	0	101,318	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	13,270	0	13,270	6.00
7.00	00700	OPERATION OF PLANT	0	46,153	0	46,153	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,033	0	19,033	8.00
9.00	00900	HOUSEKEEPING	0	2,164	0	2,164	9.00
10.00	01000	DIETARY	0	39,928	0	39,928	10.00
11.00	01100	CAFETERIA	0	11,328	0	11,328	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	39,604	0	39,604	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,054	0	28,054	14.00
15.00	01500	PHARMACY	5,402	15,172	0	20,574	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,789	0	11,789	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,708	153,690	0	168,398	30.00
31.00	03100	INTENSIVE CARE UNIT	2,175	36,916	0	39,091	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
43.00	04300	NURSERY	0	5,217	0	5,217	43.00
44.00	04400	SKILLED NURSING FACILITY	-180	18,908	0	18,728	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	61,518	0	61,518	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,693	0	4,693	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,473	0	44,473	54.00
56.00	05600	RADIOISOTOPE	0	5,126	0	5,126	56.00
57.00	05700	CT SCAN	0	3,947	0	3,947	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	41,563	0	41,563	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	9,372	4,784	0	14,156	65.00
66.00	06600	PHYSICAL THERAPY	0	30,372	0	30,372	66.00
68.00	06800	SPEECH PATHOLOGY	0	1,179	0	1,179	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,050	0	2,050	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	17,085	0	17,085	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	17,791	0	17,791	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	93,969	0	93,969	88.02
91.00	09100	EMERGENCY	0	19,432	0	19,432	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	9,150	0	0	9,150	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,684	889,675	0	934,359	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	148,864	0	148,864	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	0	843	0	843	194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
194.02	07953	ASSISTED LIVING	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	559	0	559	1	194.03
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)	45,243	1,039,382	0	1,084,625	3,206

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
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Cost Center Description			ADMINISTRATIVE E & 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	101,537					5.00
6.00	00600	MAINTENANCE & REPAIRS	4,215	17,584				6.00
7.00	00700	OPERATION OF PLANT	3,132	877	50,162			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,002	362	1,086	21,517		8.00
9.00	00900	HOUSEKEEPING	2,246	41	123	1,426	6,067	9.00
10.00	01000	DIETARY	958	758	2,277	70	0	10.00
11.00	01100	CAFETERIA	2,144	215	646	264	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	6,199	752	2,259	0	139	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,139	533	1,600	312	86	14.00
15.00	01500	PHARMACY	4,058	288	865	0	38	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,337	224	672	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,704	2,920	8,767	5,581	1,604	30.00
31.00	03100	INTENSIVE CARE UNIT	1,923	701	2,105	1,982	283	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	859	99	298	1,359	177	43.00
44.00	04400	SKILLED NURSING FACILITY	3,199	359	1,078	5,994	538	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,710	1,169	3,509	2,102	404	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	560	89	268	170	49	52.00
53.00	05300	ANESTHESIOLOGY	740	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,343	845	2,537	396	278	54.00
56.00	05600	RADIOISOTOPE	837	97	292	44	66	56.00
57.00	05700	CT SCAN	879	75	225	0	69	57.00
58.00	05800	MRI	512	0	0	0	0	58.00
60.00	06000	LABORATORY	6,658	790	2,371	67	177	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,651	91	273	0	25	65.00
66.00	06600	PHYSICAL THERAPY	5,313	577	1,732	346	744	66.00
68.00	06800	SPEECH PATHOLOGY	976	22	67	0	88	68.00
69.00	06900	ELECTROCARDIOLOGY	66	39	117	0	95	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,234	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	317	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,230	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,385	325	974	22	245	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,925	338	1,015	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	7,813	1,785	5,360	0	0	88.02
91.00	09100	EMERGENCY	3,459	369	1,108	1,382	618	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	90,723	14,740	41,624	21,517	5,723	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,516	2,828	8,490	0	344	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	2	16	48	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	1,296	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
202.00	TOTAL (sum lines 118 through 201)	101,537	17,584	50,162	21,517	6,067	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	44,012					10.00
11.00	01100	CAFETERIA	0	14,662				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	956	0	50,046		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	212	0	0	31,945	14.00
15.00	01500	PHARMACY	0	671	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,209	623	0	16,451	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,268	76	0	3,603	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	1,714	0	43.00
44.00	04400	SKILLED NURSING FACILITY	27,102	336	0	7,531	227	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	634	0	2,606	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	433	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	378	0	0	684	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	364	0	0	186	54.00
56.00	05600	RADIOISOTOPE	0	82	0	0	73	56.00
57.00	05700	CT SCAN	0	155	0	0	759	57.00
58.00	05800	MRI	0	109	0	0	129	58.00
60.00	06000	LABORATORY	0	640	0	0	12,319	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	157	0	0	285	65.00
66.00	06600	PHYSICAL THERAPY	0	2,122	0	0	261	66.00
68.00	06800	SPEECH PATHOLOGY	0	225	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	12	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	12,543	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,644	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,153	0	3,077	149	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	811	0	2,784	27	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,886	0	6,465	187	88.02
91.00	09100	EMERGENCY	0	80	0	5,815	1,440	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,012	11,683	0	50,046	30,925	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,979	0	0	1,020	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	0	0	0	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet B
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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	44,012	14,662	0	50,046	31,945	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	26,604					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,035				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING PROGRAM	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,933	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	221	0			31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0			40.00
43.00	04300	NURSERY	0	221	0			43.00
44.00	04400	SKILLED NURSING FACILITY	0	284	0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,383	0			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	95	0			52.00
53.00	05300	ANESTHESIOLOGY	0	0	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	347	0			54.00
56.00	05600	RADIOISOTOPE	0	0	0			56.00
57.00	05700	CT SCAN	0	0	0			57.00
58.00	05800	MRI	0	0	0			58.00
60.00	06000	LABORATORY	0	694	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0			64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0	0			66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,139	0	0			73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	58	0	0			88.00
88.01	08801	RURAL HEALTH CLINIC II	75	0	0			88.01
88.02	08802	RURAL HEALTH CLINIC III	103	0	0			88.02
91.00	09100	EMERGENCY	0	1,482	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0			93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0			95.00
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0			116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,375	10,660	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	229	3,375	0			192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0			194.00
194.01	07952	MEMORY DISORDER	0	0	0			194.01
194.02	07953	ASSISTED LIVING	0	0	0			194.02
194.03	07951	CONTRACTED RETAIL RX	0	0	0			194.03
200.00		Cross Foot Adjustments				0	0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
		15.00	16.00	17.00	19.00	20.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	26,604	14,035	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				229,428	0	30.00
31.00	03100	INTENSIVE CARE UNIT				52,315	0	31.00
40.00	04000	SUBPROVIDER - IPF				0	0	40.00
43.00	04300	NURSERY				9,971	0	43.00
44.00	04400	SKILLED NURSING FACILITY				65,487	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				80,117	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				6,376	0	52.00
53.00	05300	ANESTHESIOLOGY				1,923	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				52,852	0	54.00
56.00	05600	RADIOISOTOPE				6,628	0	56.00
57.00	05700	CT SCAN				6,125	0	57.00
58.00	05800	MRI				758	0	58.00
60.00	06000	LABORATORY				65,396	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
64.00	06400	INTRAVENOUS THERAPY				0	0	64.00
65.00	06500	RESPIRATORY THERAPY				16,689	0	65.00
66.00	06600	PHYSICAL THERAPY				41,647	0	66.00
68.00	06800	SPEECH PATHOLOGY				2,578	0	68.00
69.00	06900	ELECTROCARDIOLOGY				2,379	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				14,777	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				1,961	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				31,369	0	73.00
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC				26,584	0	88.00
88.01	08801	RURAL HEALTH CLINIC II				25,866	0	88.01
88.02	08802	RURAL HEALTH CLINIC III				117,793	0	88.02
91.00	09100	EMERGENCY				35,452	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM				0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES				0	0	95.00
99.10	09910	CORF				0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				0	0	99.40
101.00	10100	HOME HEALTH AGENCY				9,150	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE				0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	903,621	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES				178,239	0	192.00
194.00	07950	OTHER NONREIMBURSABLE				0	0	194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

 Period:
 From 01/01/2021
 To 12/31/2021

 Worksheet B
 Part II
 Date/Time Prepared:
 5/26/2022 11:09 am

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00				
194.01	07952	MEMORY DISORDER				909	0	194.01
194.02	07953	ASSISTED LIVING				0	0	194.02
194.03	07951	CONTRACTED RETAIL RX				1,856	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	1,084,625	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING PROGRAM	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
88.02	08802	RURAL HEALTH CLINIC III	88.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	OTHER NONREIMBURSABLE	194.00
194.01	07952	MEMORY DISORDER	194.01
194.02	07953	ASSISTED LIVING	194.02
194.03	07951	CONTRACTED RETAIL RX	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MOVABLE EQUIP (DOLLAR VALUE -NEW)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	182,505					1.00
2.00	00200	CAP REL COSTS-MVABLE EQUIP		1,719,118				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	563	0	29,165,627			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,078	324,315	1,987,063	-10,038,198	43,041,026	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,330	168,458	903,721	0	1,786,938	6.00
7.00	00700	OPERATION OF PLANT	8,104	0	0	0	1,327,545	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,342	12,205	311,418	0	424,636	8.00
9.00	00900	HOUSEKEEPING	380	3,647	608,382	0	952,231	9.00
10.00	01000	DIETARY	7,011	16,415	195,193	0	406,115	10.00
11.00	01100	CAFETERIA	1,989	0	591,692	0	908,857	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	6,954	190,717	1,247,498	0	2,627,641	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,926	29,180	78,209	0	482,621	14.00
15.00	01500	PHARMACY	2,664	54,492	1,001,480	0	1,720,210	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,070	3,301	0	0	566,731	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,987	39,445	2,161,573	0	3,265,951	30.00
31.00	03100	INTENSIVE CARE UNIT	6,482	12,134	561,658	0	815,227	31.00
40.00	04000	SUBPROVIDER - IPF	0	190	0	0	0	40.00
43.00	04300	NURSERY	916	3,815	248,600	0	364,341	43.00
44.00	04400	SKILLED NURSING FACILITY	3,320	10,709	1,007,862	0	1,356,071	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,802	141,232	749,307	0	1,572,646	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	824	1,103	170,743	0	237,453	52.00
53.00	05300	ANESTHESIOLOGY	0	49,374	1,100,680	0	313,668	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,809	191,771	754,040	0	1,417,228	54.00
56.00	05600	RADIOISOTOPE	900	22,400	103,757	0	354,701	56.00
57.00	05700	CT SCAN	693	19,610	148,471	0	372,587	57.00
58.00	05800	MRI	0	242,304	73,522	0	217,119	58.00
60.00	06000	LABORATORY	7,298	72,438	1,060,268	0	2,822,420	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	840	10,794	463,019	0	699,860	65.00
66.00	06600	PHYSICAL THERAPY	5,333	20,324	1,635,021	0	2,252,151	66.00
68.00	06800	SPEECH PATHOLOGY	207	2,356	189,630	0	413,585	68.00
69.00	06900	ELECTROCARDIOLOGY	360	9,339	0	0	28,040	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	947,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	134,441	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,216,866	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,000	14,345	1,011,655	0	1,434,827	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,124	0	906,065	0	1,239,990	88.01
88.02	08802	RURAL HEALTH CLINIC III	16,500	0	2,044,250	0	3,312,196	88.02
91.00	09100	EMERGENCY	3,412	28,080	2,431,458	0	1,466,267	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	156,218	1,694,493	23,746,235	-10,038,198	38,458,235	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,139	24,625	5,413,974	0	4,032,590	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VAL UE -NEW)				
			1.00	2.00	4.00	5A	5.00	
194.01	07952	MEMORY DISORDER	148	0	0	0	843	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	0	0	5,418	0	549,358	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,039,382	0	958,639		10,038,198	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.695088	0.000000	0.032869		0.233224	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,206		101,537	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000110		0.002359	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: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY PO UNDS)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (DIETARY ME ALS SERV)	
		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	162,534				6.00
7.00	00700	OPERATION OF PLANT	8,104	154,430			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,342	3,342	461,198		8.00
9.00	00900	HOUSEKEEPING	380	380	30,570	5,769	9.00
10.00	01000	DIETARY	7,011	7,011	1,505	0	10.00
11.00	01100	CAFETERIA	1,989	1,989	5,661	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	6,954	6,954	0	132	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,926	4,926	6,684	82	14.00
15.00	01500	PHARMACY	2,664	2,664	0	36	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,070	2,070	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,987	26,987	119,623	1,525	30.00
31.00	03100	INTENSIVE CARE UNIT	6,482	6,482	42,476	269	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
43.00	04300	NURSERY	916	916	29,138	168	43.00
44.00	04400	SKILLED NURSING FACILITY	3,320	3,320	128,441	512	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,802	10,802	45,062	384	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	824	824	3,651	47	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,809	7,809	8,498	264	54.00
56.00	05600	RADIOISOTOPE	900	900	952	63	56.00
57.00	05700	CT SCAN	693	693	0	66	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	7,298	7,298	1,438	168	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	840	840	0	24	65.00
66.00	06600	PHYSICAL THERAPY	5,333	5,333	7,411	707	66.00
68.00	06800	SPEECH PATHOLOGY	207	207	0	84	68.00
69.00	06900	ELECTROCARDIOLOGY	360	360	0	90	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,000	3,000	474	233	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,124	3,124	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	16,500	16,500	0	0	88.02
91.00	09100	EMERGENCY	3,412	3,412	29,614	588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	136,247	128,143	461,198	5,442	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,139	26,139	0	327	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	148	148	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	0	0	0	0	194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY PO UNDS)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (DIETARY ME ALS SERV)	
		6.00	7.00	8.00	9.00	10.00	
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)	2,203,695	1,747,037	606,790	1,223,985	677,183	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	13.558363	11.312808	1.315682	212.165887	61.101056	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	17,584	50,162	21,517	6,067	44,012	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.108187	0.324820	0.046655	1.051655	3.971127	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: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:

5/26/2022 11:09 am

Cost Center Description		CAFETERIA (CAFE MEALS SERV)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATIO N (DIRECT NUR SING HO)	CENTRAL SERVICES & SUPPLY (CS COSTED REQUIS)	PHARMACY (PHARM COST ED REQ)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	276,187				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	18,002	0	247,175		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,993	0	0	2,040,969	14.00
15.00	01500	PHARMACY	12,643	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	241	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,741	0	81,248	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,435	0	17,795	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	8,467	0	43.00
44.00	04400	SKILLED NURSING FACILITY	6,331	0	37,195	14,482	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,938	0	12,871	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	7,120	0	0	43,700	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,852	0	0	11,899	54.00
56.00	05600	RADIOISOTOPE	1,546	0	0	4,688	56.00
57.00	05700	CT SCAN	2,925	0	0	48,470	57.00
58.00	05800	MRI	2,044	0	0	8,219	58.00
60.00	06000	LABORATORY	12,048	0	0	787,082	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,960	0	0	18,194	65.00
66.00	06600	PHYSICAL THERAPY	39,974	0	0	16,658	66.00
68.00	06800	SPEECH PATHOLOGY	4,232	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	748	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	801,421	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	105,040	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	21,722	0	15,197	9,546	88.00
88.01	08801	RURAL HEALTH CLINIC II	15,275	0	13,752	1,741	88.01
88.02	08802	RURAL HEALTH CLINIC III	35,521	0	31,930	11,941	88.02
91.00	09100	EMERGENCY	1,506	0	28,720	92,002	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	220,049	0	247,175	1,975,831	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	56,138	0	0	65,138	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	0	0	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	194.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			CAFETERIA (CAFE MEALS SERV)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATIO N (DIRECT NUR SING HO)	CENTRAL SERVICES & SUPPLY (CS COSTED REQUIS)	PHARMACY (PHARM COST ED REQ)	
			11.00	12.00	13.00	14.00	15.00	
194.03	07951	CONTRACTED RETAIL RX	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,177,741	0	3,518,196	760,914	2,249,211	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.264288	0.000000	14.233624	0.372820	1.493504	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,662	0	50,046	31,945	26,604	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.053087	0.000000	0.202472	0.015652	0.017665	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: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALA RY & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	445					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING PROGRAM	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	93	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	7	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	9	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	139	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	22	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	47	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0		0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	338	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	107	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALA RY & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
194.01	07952	MEMORY DISORDER	0	0	0	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	0	0	0	0	0	194.03
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)	751,418	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,688.579775	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,035	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	31.539326	0.000000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)		
			SERVICES-OTHE R PRGM COSTS APPRV (ASSIGNED TIME)			
			22.00			23.00
			GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00	
5.00	00500	ADMINISTRATIVE & GENERAL			5.00	
6.00	00600	MAINTENANCE & REPAIRS			6.00	
7.00	00700	OPERATION OF PLANT			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE			8.00	
9.00	00900	HOUSEKEEPING			9.00	
10.00	01000	DIETARY			10.00	
11.00	01100	CAFETERIA			11.00	
12.00	01200	MAINTENANCE OF PERSONNEL			12.00	
13.00	01300	NURSING ADMINISTRATION			13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00	
15.00	01500	PHARMACY			15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00	
17.00	01700	SOCIAL SERVICE			17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00	
20.00	02000	NURSING PROGRAM			20.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		22.00	
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	40.00	
43.00	04300	NURSERY	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00	
56.00	05600	RADIOISOTOPE	0	0	56.00	
57.00	05700	CT SCAN	0	0	57.00	
58.00	05800	MRI	0	0	58.00	
60.00	06000	LABORATORY	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30	
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	66.00	
68.00	06800	SPEECH PATHOLOGY	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00	
76.97	07697	CARDIAC REHABILITATION	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01	
88.02	08802	RURAL HEALTH CLINIC III	0	0	88.02	
91.00	09100	EMERGENCY	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99	
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	95.00	
99.10	09910	CORF	0	0	99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40	
101.00	10100	HOME HEALTH AGENCY	0	0	101.00	
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE		0	116.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	118.00	
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00	
194.00	07950	OTHER NONREIMBURSABLE	0	0	194.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)	
			SERVICES-OTHE R PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00	23.00	
194.01	07952	MEMORY DISORDER	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	0	0	194.03
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)	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/26/2022 11:09 am

			Title XVIII		Hospital		PPS
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,761,962		6,761,962	0	6,761,962
31.00	03100	INTENSIVE CARE UNIT	1,585,646		1,585,646	0	1,585,646
40.00	04000	SUBPROVIDER - IPF	0		0	0	0
43.00	04300	NURSERY	678,412		678,412	0	678,412
44.00	04400	SKILLED NURSING FACILITY	3,026,554		3,026,554	0	3,026,554
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,817,663		2,817,663	0	2,817,663
52.00	05200	DELIVERY ROOM & LABOR ROOM	339,829		339,829	0	339,829
53.00	05300	ANESTHESIOLOGY	433,477		433,477	0	433,477
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,061,401		2,061,401	0	2,061,401
56.00	05600	RADIOISOTOPE	482,771		482,771	0	482,771
57.00	05700	CT SCAN	521,266		521,266	0	521,266
58.00	05800	MRI	279,536		279,536	0	279,536
60.00	06000	LABORATORY	4,081,687		4,081,687	0	4,081,687
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0
65.00	06500	RESPIRATORY THERAPY	908,473	0	908,473	0	908,473
66.00	06600	PHYSICAL THERAPY	3,246,468	0	3,246,468	0	3,246,468
68.00	06800	SPEECH PATHOLOGY	551,060	0	551,060	0	551,060
69.00	06900	ELECTROCARDIOLOGY	62,908		62,908	0	62,908
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,466,865		1,466,865	0	1,466,865
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	204,957		204,957	0	204,957
73.00	07300	DRUGS CHARGED TO PATIENTS	4,943,815		4,943,815	0	4,943,815
76.97	07697	CARDIAC REHABILITATION	0		0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0
76.99	07699	LITHOTRIPSY	0		0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,211,510		2,211,510	0	2,211,510
88.01	08801	RURAL HEALTH CLINIC II	1,874,620		1,874,620	0	1,874,620
88.02	08802	RURAL HEALTH CLINIC III	5,114,198		5,114,198	0	5,114,198
91.00	09100	EMERGENCY	2,585,688		2,585,688	0	2,585,688
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,018,141		2,018,141	0	2,018,141
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0		0	0	0
99.10	09910	CORF	0		0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0	0
101.00	10100	HOME HEALTH AGENCY	0		0	0	0
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0		0	0	0
200.00		Subtotal (see instructions)	48,258,907	0	48,258,907	0	48,258,907
201.00		Less Observation Beds	2,018,141		2,018,141	0	2,018,141
202.00		Total (see instructions)	46,240,766	0	46,240,766	0	46,240,766

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/26/2022 11:09 am

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,500,918		4,500,918		30.00
31.00	03100	INTENSIVE CARE UNIT	2,810,371		2,810,371		31.00
40.00	04000	SUBPROVIDER - IPF	0		0		40.00
43.00	04300	NURSERY	316,602		316,602		43.00
44.00	04400	SKILLED NURSING FACILITY	1,344,294		1,344,294		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,415,518	8,084,933	10,500,451	0.268337	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	419,520	905	420,425	0.808299	0.000000
53.00	05300	ANESTHESIOLOGY	0	3,329,694	3,329,694	0.130185	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,262,035	10,702,764	11,964,799	0.172289	0.000000
56.00	05600	RADIOISOTOPE	124,265	3,293,820	3,418,085	0.141240	0.000000
57.00	05700	CT SCAN	2,764,860	18,512,959	21,277,819	0.024498	0.000000
58.00	05800	MRI	280,800	4,950,673	5,231,473	0.053434	0.000000
60.00	06000	LABORATORY	5,581,871	24,993,045	30,574,916	0.133498	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	3,493,159	831,246	4,324,405	0.210080	0.000000
66.00	06600	PHYSICAL THERAPY	1,297,125	13,497,892	14,795,017	0.219430	0.000000
68.00	06800	SPEECH PATHOLOGY	128,100	951,661	1,079,761	0.510354	0.000000
69.00	06900	ELECTROCARDIOLOGY	499,425	2,364,528	2,863,953	0.021965	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,013,617	2,756,132	3,769,749	0.389115	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	453,012	403,898	856,910	0.239181	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	6,809,186	9,522,581	16,331,767	0.302712	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,888,549	1,888,549		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,285,189	2,285,189		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	4,007,160	4,007,160		88.02
91.00	09100	EMERGENCY	2,324,903	14,501,422	16,826,325	0.153669	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	512,093	6,253,936	6,766,029	0.298276	0.000000
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	38,351,674	133,132,987	171,484,661		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	38,351,674	133,132,987	171,484,661		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.268337		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.808299		52.00
53.00	05300	ANESTHESIOLOGY	0.130185		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.172289		54.00
56.00	05600	RADIOISOTOPE	0.141240		56.00
57.00	05700	CT SCAN	0.024498		57.00
58.00	05800	MRI	0.053434		58.00
60.00	06000	LABORATORY	0.133498		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.210080		65.00
66.00	06600	PHYSICAL THERAPY	0.219430		66.00
68.00	06800	SPEECH PATHOLOGY	0.510354		68.00
69.00	06900	ELECTROCARDIOLOGY	0.021965		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.389115		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.239181		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302712		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
91.00	09100	EMERGENCY	0.153669		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.298276		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		93.99
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/26/2022 11:09 am

			Title XIX		Hospital		PPS
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,761,962		6,761,962	0	6,761,962
31.00	03100	INTENSIVE CARE UNIT	1,585,646		1,585,646	0	1,585,646
40.00	04000	SUBPROVIDER - IPF	0		0	0	0
43.00	04300	NURSERY	678,412		678,412	0	678,412
44.00	04400	SKILLED NURSING FACILITY	3,026,554		3,026,554	0	3,026,554
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,817,663		2,817,663	0	2,817,663
52.00	05200	DELIVERY ROOM & LABOR ROOM	339,829		339,829	0	339,829
53.00	05300	ANESTHESIOLOGY	433,477		433,477	0	433,477
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,061,401		2,061,401	0	2,061,401
56.00	05600	RADIOISOTOPE	482,771		482,771	0	482,771
57.00	05700	CT SCAN	521,266		521,266	0	521,266
58.00	05800	MRI	279,536		279,536	0	279,536
60.00	06000	LABORATORY	4,081,687		4,081,687	0	4,081,687
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0
65.00	06500	RESPIRATORY THERAPY	908,473	0	908,473	0	908,473
66.00	06600	PHYSICAL THERAPY	3,246,468	0	3,246,468	0	3,246,468
68.00	06800	SPEECH PATHOLOGY	551,060	0	551,060	0	551,060
69.00	06900	ELECTROCARDIOLOGY	62,908		62,908	0	62,908
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,466,865		1,466,865	0	1,466,865
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	204,957		204,957	0	204,957
73.00	07300	DRUGS CHARGED TO PATIENTS	4,943,815		4,943,815	0	4,943,815
76.97	07697	CARDIAC REHABILITATION	0		0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0
76.99	07699	LITHOTRIPSY	0		0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,211,510		2,211,510	0	2,211,510
88.01	08801	RURAL HEALTH CLINIC II	1,874,620		1,874,620	0	1,874,620
88.02	08802	RURAL HEALTH CLINIC III	5,114,198		5,114,198	0	5,114,198
91.00	09100	EMERGENCY	2,585,688		2,585,688	0	2,585,688
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,018,141		2,018,141	0	2,018,141
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0		0	0	0
99.10	09910	CORF	0		0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0	0
101.00	10100	HOME HEALTH AGENCY	0		0	0	0
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0		0	0	0
200.00		Subtotal (see instructions)	48,258,907	0	48,258,907	0	48,258,907
201.00		Less Observation Beds	2,018,141		2,018,141		2,018,141
202.00		Total (see instructions)	46,240,766	0	46,240,766	0	46,240,766

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/26/2022 11:09 am

			Title XIX			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	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00	
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00	
40.00	04000	SUBPROVIDER - IPF	0		0			40.00	
43.00	04300	NURSERY	0		0			43.00	
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00	
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00	
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00	
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00	
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0.000000	0.000000	88.01	
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0.000000	0.000000	88.02	
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00	
99.10	09910	CORF	0	0	0			99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40	
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00	
	SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0			116.00	
200.00		Subtotal (see instructions)	0	0	0			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	0	0	0			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000			88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000			88.02
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE				116.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part II
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description		Title XIX			Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,817,663	80,117	2,737,546	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	339,829	6,376	333,453	0	0	52.00
53.00	05300	ANESTHESIOLOGY	433,477	1,923	431,554	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,061,401	52,852	2,008,549	0	0	54.00
56.00	05600	RADIOISOTOPE	482,771	6,628	476,143	0	0	56.00
57.00	05700	CT SCAN	521,266	6,125	515,141	0	0	57.00
58.00	05800	MRI	279,536	758	278,778	0	0	58.00
60.00	06000	LABORATORY	4,081,687	65,396	4,016,291	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	908,473	16,689	891,784	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,246,468	41,647	3,204,821	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	551,060	2,578	548,482	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	62,908	2,379	60,529	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,466,865	14,777	1,452,088	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	204,957	1,961	202,996	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,943,815	31,369	4,912,446	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,211,510	26,584	2,184,926	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,874,620	25,866	1,848,754	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,114,198	117,793	4,996,405	0	0	88.02
91.00	09100	EMERGENCY	2,585,688	35,452	2,550,236	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,018,141	68,474	1,949,667	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	9,150	-9,150	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	36,206,333	614,894	35,591,439	0	0	200.00
201.00		Less Observation Beds	2,018,141	68,474	1,949,667	0	0	201.00
202.00		Total (line 200 minus line 201)	34,188,192	546,420	33,641,772	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part II
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Title XIX		Hospital	PPS
			Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,817,663	10,500,451	0.268337	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	339,829	420,425	0.808299	52.00
53.00	05300	ANESTHESIOLOGY	433,477	3,329,694	0.130185	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,061,401	11,964,799	0.172289	54.00
56.00	05600	RADIOISOTOPE	482,771	3,418,085	0.141240	56.00
57.00	05700	CT SCAN	521,266	21,277,819	0.024498	57.00
58.00	05800	MRI	279,536	5,231,473	0.053434	58.00
60.00	06000	LABORATORY	4,081,687	30,574,916	0.133498	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	908,473	4,324,405	0.210080	65.00
66.00	06600	PHYSICAL THERAPY	3,246,468	14,795,017	0.219430	66.00
68.00	06800	SPEECH PATHOLOGY	551,060	1,079,761	0.510354	68.00
69.00	06900	ELECTROCARDIOLOGY	62,908	2,863,953	0.021965	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,466,865	3,769,749	0.389115	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	204,957	856,910	0.239181	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,943,815	16,331,767	0.302712	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,211,510	1,888,549	1.171010	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,874,620	2,285,189	0.820335	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,114,198	4,007,160	1.276265	88.02
91.00	09100	EMERGENCY	2,585,688	16,826,325	0.153669	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,018,141	6,766,029	0.298276	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	95.00
99.10	09910	CORF	0	0	0.000000	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0.000000	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0.000000	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0.000000	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0.000000	116.00
200.00		Subtotal (sum of lines 50 thru 199)	36,206,333	162,512,476		200.00
201.00		Less Observation Beds	2,018,141	0		201.00
202.00		Total (line 200 minus line 201)	34,188,192	162,512,476		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 14-0147	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Prepared: 5/26/2022 11:09 am	
				Title XVIII	Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	229,428	6,064	223,364	4,133	54.04	30.00
31.00	INTENSIVE CARE UNIT	52,315		52,315	787	66.47	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
43.00	NURSERY	9,971		9,971	326	30.59	43.00
44.00	SKILLED NURSING FACILITY	65,487		65,487	5,721	11.45	44.00
200.00	Total (lines 30 through 199)	357,201		351,137	10,967		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	1,443	77,980				30.00
31.00	INTENSIVE CARE UNIT	395	26,256				31.00
40.00	SUBPROVIDER - IPF	0	0				40.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	1,838	104,236				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			Title XVIII		Hospital	PPS		
			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	80,117	10,500,451	0.007630	1,048,972	8,004	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,376	420,425	0.015166	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,923	3,329,694	0.000578	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,852	11,964,799	0.004417	482,592	2,132	54.00
56.00	05600	RADIOISOTOPE	6,628	3,418,085	0.001939	23,160	45	56.00
57.00	05700	CT SCAN	6,125	21,277,819	0.000288	1,377,204	397	57.00
58.00	05800	MRI	758	5,231,473	0.000145	7,780	1	58.00
60.00	06000	LABORATORY	65,396	30,574,916	0.002139	3,038,040	6,498	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	16,689	4,324,405	0.003859	1,827,374	7,052	65.00
66.00	06600	PHYSICAL THERAPY	41,647	14,795,017	0.002815	418,090	1,177	66.00
68.00	06800	SPEECH PATHOLOGY	2,578	1,079,761	0.002388	53,215	127	68.00
69.00	06900	ELECTROCARDIOLOGY	2,379	2,863,953	0.000831	481,670	400	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,777	3,769,749	0.003920	438,483	1,719	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,961	856,910	0.002288	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,369	16,331,767	0.001921	3,343,743	6,423	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	26,584	1,888,549	0.014076	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	25,866	2,285,189	0.011319	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	117,793	4,007,160	0.029396	0	0	88.02
91.00	09100	EMERGENCY	35,452	16,826,325	0.002107	1,181,400	2,489	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	68,474	6,766,029	0.010120	241,675	2,446	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	605,744	162,512,476		13,963,398	38,910	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part III
Date/Time Prepared:
5/26/2022 11:09 am

				Title XVIII		Hospital	PPS		
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	4,133	0.00	1,443	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	787	0.00	395	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00	
43.00	04300	NURSERY		0	326	0.00	0	43.00	
44.00	04400	SKILLED NURSING FACILITY		0	5,721	0.00	0	44.00	
200.00		Total (lines 30 through 199)		0	10,967		1,838	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
43.00	04300	NURSERY	0						43.00
44.00	04400	SKILLED NURSING FACILITY	0						44.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0147		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/26/2022 11:09 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III		0	0	0	0	0	88.02
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
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		0	0	0	0	0	95.00
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: 14-0147		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/26/2022 11:09 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	10,500,451	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	420,425	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	3,329,694	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	11,964,799	0.000000	54.00
56.00	05600	RADIOISOTOPE		0	0	0	3,418,085	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	21,277,819	0.000000	57.00
58.00	05800	MRI		0	0	0	5,231,473	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	30,574,916	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	4,324,405	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	14,795,017	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,079,761	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	2,863,953	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	3,769,749	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	856,910	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	16,331,767	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	1,888,549	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	2,285,189	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III		0	0	0	4,007,160	0.000000	88.02
91.00	09100	EMERGENCY		0	0	0	16,826,325	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	6,766,029	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)		0	0	0	162,512,476		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/26/2022 11:09 am

				Title XVIII		Hospital	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	1,048,972	0	3,982,332	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	482,592	0	2,668,645	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	23,160	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	1,377,204	0	6,216,140	0	57.00
58.00	05800	MRI	0.000000	7,780	0	159,760	0	58.00
60.00	06000	LABORATORY	0.000000	3,038,040	0	3,414,604	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,827,374	0	305,359	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	418,090	0	77,176	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	53,215	0	75,270	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	481,670	0	1,744,410	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	438,483	0	562,204	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	43,641	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,343,743	0	3,528,682	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
91.00	09100	EMERGENCY	0.000000	1,181,400	0	3,580,682	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	241,675	0	2,217,675	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		13,963,398	0	28,576,580	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/26/2022 11:09 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.268337	3,982,332	0	0	1,068,607	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.808299	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.130185	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.172289	2,668,645	0	0	459,778	54.00
56.00	05600	RADIOISOTOPE	0.141240	0	0	0	0	56.00
57.00	05700	CT SCAN	0.024498	6,216,140	0	0	152,283	57.00
58.00	05800	MRI	0.053434	159,760	0	0	8,537	58.00
60.00	06000	LABORATORY	0.133498	3,414,604	0	0	455,843	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.210080	305,359	0	0	64,150	65.00
66.00	06600	PHYSICAL THERAPY	0.219430	77,176	0	0	16,935	66.00
68.00	06800	SPEECH PATHOLOGY	0.510354	75,270	0	0	38,414	68.00
69.00	06900	ELECTROCARDIOLOGY	0.021965	1,744,410	0	0	38,316	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.389115	562,204	0	0	218,762	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.239181	43,641	0	3,117	10,438	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302712	3,528,682	0	0	1,068,174	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
91.00	09100	EMERGENCY	0.153669	3,580,682	0	0	550,240	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.298276	2,217,675	0	0	661,479	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		28,576,580	0	3,117	4,811,956	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		28,576,580	0	3,117	4,811,956	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/26/2022 11:09 am

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	746		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	746		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	746		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0147 Component CCN: 14-S147	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Prepared: 5/26/2022 11:09 am	
				Title XVIII	Subprovider - IPF	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	80,117	10,500,451	0.007630	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,376	420,425	0.015166	0	52.00
53.00	05300	ANESTHESIOLOGY	1,923	3,329,694	0.000578	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,852	11,964,799	0.004417	0	54.00
56.00	05600	RADIOISOTOPE	6,628	3,418,085	0.001939	0	56.00
57.00	05700	CT SCAN	6,125	21,277,819	0.000288	0	57.00
58.00	05800	MRI	758	5,231,473	0.000145	0	58.00
60.00	06000	LABORATORY	65,396	30,574,916	0.002139	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	16,689	4,324,405	0.003859	0	65.00
66.00	06600	PHYSICAL THERAPY	41,647	14,795,017	0.002815	0	66.00
68.00	06800	SPEECH PATHOLOGY	2,578	1,079,761	0.002388	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,379	2,863,953	0.000831	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,777	3,769,749	0.003920	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,961	856,910	0.002288	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,369	16,331,767	0.001921	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	26,584	1,888,549	0.014076	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	25,866	2,285,189	0.011319	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	117,793	4,007,160	0.029396	0	88.02
91.00	09100	EMERGENCY	35,452	16,826,325	0.002107	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,766,029	0.000000	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	537,270	162,512,476		0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/26/2022 11:09 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/26/2022 11:09 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	10,500,451	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	420,425	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	3,329,694	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	11,964,799	0.000000	54.00
56.00	05600	RADIOISOTOPE		0	0	0	3,418,085	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	21,277,819	0.000000	57.00
58.00	05800	MRI		0	0	0	5,231,473	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	30,574,916	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	4,324,405	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	14,795,017	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,079,761	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	2,863,953	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	3,769,749	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	856,910	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	16,331,767	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	1,888,549	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	2,285,189	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III		0	0	0	4,007,160	0.000000	88.02
91.00	09100	EMERGENCY		0	0	0	16,826,325	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	6,766,029	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)		0	0	0	162,512,476		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/26/2022 11:09 am	
				Title XVIII		Subprovider - IPF		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	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES			0	0	0	0	95.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
5/26/2022 11:09 am

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	229,428	6,064	223,364	4,133	54.04	30.00
31.00	INTENSIVE CARE UNIT	52,315		52,315	787	66.47	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
43.00	NURSERY	9,971		9,971	326	30.59	43.00
44.00	SKILLED NURSING FACILITY	65,487		65,487	5,721	11.45	44.00
200.00	Total (lines 30 through 199)	357,201		351,137	10,967		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	444	23,994				30.00
31.00	INTENSIVE CARE UNIT	91	6,049				31.00
40.00	SUBPROVIDER - IPF	0	0				40.00
43.00	NURSERY	188	5,751				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	723	35,794				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			Title XIX		Hospital		PPS
			Capital Related Cost (from Wkst. C, 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	80,117	0	0.000000	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,376	0	0.000000	0	0 52.00
53.00	05300	ANESTHESIOLOGY	1,923	0	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,852	0	0.000000	0	0 54.00
56.00	05600	RADIOISOTOPE	6,628	0	0.000000	0	0 56.00
57.00	05700	CT SCAN	6,125	0	0.000000	0	0 57.00
58.00	05800	MRI	758	0	0.000000	0	0 58.00
60.00	06000	LABORATORY	65,396	0	0.000000	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	16,689	0	0.000000	0	0 65.00
66.00	06600	PHYSICAL THERAPY	41,647	0	0.000000	0	0 66.00
68.00	06800	SPEECH PATHOLOGY	2,578	0	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	2,379	0	0.000000	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,777	0	0.000000	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,961	0	0.000000	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,369	0	0.000000	0	0 73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	26,584	0	0.000000	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	25,866	0	0.000000	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	117,793	0	0.000000	0	0 88.02
91.00	09100	EMERGENCY	35,452	0	0.000000	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	68,474	0	0.000000	0	0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0 93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	605,744	0		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part III
Date/Time Prepared:
5/26/2022 11:09 am

				Title XIX		Hospital		PPS		
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	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	4,133	0.00	444	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	787	0.00	91	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	0	40.00	
43.00	04300	NURSERY		0	326	0.00	188	0	43.00	
44.00	04400	SKILLED NURSING FACILITY		0	5,721	0.00	0	0	44.00	
200.00		Total (lines 30 through 199)		0	10,967		723	0	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0							30.00
31.00	03100	INTENSIVE CARE UNIT	0							31.00
40.00	04000	SUBPROVIDER - IPF	0							40.00
43.00	04300	NURSERY	0							43.00
44.00	04400	SKILLED NURSING FACILITY	0							44.00
200.00		Total (lines 30 through 199)	0							200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			Title XIX		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
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
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
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: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			Title XIX		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	0	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description			Title XIX		Hospital		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	0	0	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0 54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0 56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0 57.00
58.00	05800	MRI	0.000000	0	0	0	0 58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0 66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0 73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0 88.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0 93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)		0	0	0	0 200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-0147 Component CCN:14-S147		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part II Date/Time Prepared: 5/26/2022 11:09 am	
				Title XIX		Subprovider - IPF		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	80,117	0	0.000000	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,376	0	0.000000	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	1,923	0	0.000000	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,852	0	0.000000	0	0	54.00	
56.00	05600	RADIOISOTOPE	6,628	0	0.000000	0	0	56.00	
57.00	05700	CT SCAN	6,125	0	0.000000	0	0	57.00	
58.00	05800	MRI	758	0	0.000000	0	0	58.00	
60.00	06000	LABORATORY	65,396	0	0.000000	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30	
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	16,689	0	0.000000	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	41,647	0	0.000000	0	0	66.00	
68.00	06800	SPEECH PATHOLOGY	2,578	0	0.000000	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	2,379	0	0.000000	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,777	0	0.000000	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,961	0	0.000000	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	31,369	0	0.000000	0	0	73.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	26,584	0	0.000000	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	25,866	0	0.000000	0	0	88.01	
88.02	08802	RURAL HEALTH CLINIC III	117,793	0	0.000000	0	0	88.02	
91.00	09100	EMERGENCY	35,452	0	0.000000	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00	
200.00		Total (lines 50 through 199)	537,270	0		0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/26/2022 11:09 am	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/26/2022 11:09 am	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0.000000	54.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	0	0.000000	57.00
58.00	05800	MRI		0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	0	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III		0	0	0	0	0.000000	88.02
91.00	09100	EMERGENCY		0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)		0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:14-0147 Component CCN:14-S147		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/26/2022 11:09 am	
				Title XIX		Subprovider - IPF		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	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES			0	0	0	0	95.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0147	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/26/2022 11:09 am	
Cost Center Description		Title XVIII	Hospital	PPS	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,884	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,133	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)			2,866	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			751	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			1,443	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)			751	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			237.99	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			243.34	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			224.47	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			224.47	20.00
21.00	Total general inpatient routine service cost (see instructions)			6,761,962	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)			178,730	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)			178,730	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			6,583,232	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)			6,583,232	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,592.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,298,483	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)			2,298,483	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet D-1

Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description		Title XVIII			Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,585,646	787	2,014.80	395	795,846	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)					2,757,437	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,851,766	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)					104,236	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					38,910	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					143,146	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,708,620	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)					178,730	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)					178,730	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,267	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,592.85	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,018,141	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet D-1

Date/Time Prepared:
5/26/2022 11:09 am

		Title XVIII		Hospital	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	229,428	6,761,962	0.033929	2,018,141	68,474
91.00	Nursing Program cost	0	6,761,962	0.000000	2,018,141	0
92.00	Allied health cost	0	6,761,962	0.000000	2,018,141	0
93.00	All other Medical Education	0	6,761,962	0.000000	2,018,141	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0147 Component CCN: 14-S147	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/26/2022 11:09 am
		Title XVIII	Subprovider - IPF	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)		0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		0	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)		0	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		0	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)		0	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)		0	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)		0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0147	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1	
				Component CCN: 14-S147		Date/Time Prepared: 5/26/2022 11:09 am	
				Title XVIII		Subprovider - IPF	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)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/26/2022 11:09 am	
			Title XVIII		Subprovider - IPF	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0147 Component CCN: 14-5580	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/26/2022 11:09 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,721	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,721	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,721	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,026,554	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,026,554	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,026,554	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0147 Component CCN: 14-5580	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/26/2022 11:09 am		
				Title XVIII		Skilled Nursing Facility	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT						43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description								
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00	
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00	
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00	
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00	
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00	
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						54.00	
55.00	Target amount per discharge						55.00	
56.00	Target amount (line 54 x line 55)						56.00	
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00	
58.00	Bonus payment (see instructions)						58.00	
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00	
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00	
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00	
62.00	Relief payment (see instructions)						62.00	
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00	
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00	
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00	
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00	
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00	
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						3,026,554	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						529.03	71.00
72.00	Program routine service cost (line 9 x line 71)						0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)						0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						0	80.00
81.00	Inpatient routine service cost per diem limitation						0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)						0	83.00
84.00	Program inpatient ancillary services (see instructions)						0	84.00
85.00	Utilization review - physician compensation (see instructions)						0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						0	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0147 Component CCN: 14-5580		Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/26/2022 11:09 am	
			Title XVIII		Skilled Nursing Facility	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0147	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/26/2022 11:09 am	
		Title XIX	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)			4,884	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,133	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)			2,866	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			751	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			444	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			326	15.00
16.00	Nursery days (title V or XIX only)			188	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			237.99	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			243.34	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			224.47	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			224.47	20.00
21.00	Total general inpatient routine service cost (see instructions)			6,761,962	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)			178,730	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)			178,730	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			6,583,232	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)			6,583,232	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,592.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			707,225	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)			707,225	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet D-1

Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description		Title XIX		Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	678,412	326	2,081.02	188	391,232	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,585,646	787	2,014.80	91	183,347	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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,281,804	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)					35,794	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					35,794	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,246,010	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,267	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,592.85	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,018,141	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-0147		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/26/2022 11:09 am	
				Title XIX		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	229,428	6,761,962	0.033929	2,018,141	68,474	90.00		
91.00	Nursing Program cost	0	6,761,962	0.000000	2,018,141	0	91.00		
92.00	Allied health cost	0	6,761,962	0.000000	2,018,141	0	92.00		
93.00	All other Medical Education	0	6,761,962	0.000000	2,018,141	0	93.00		

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0147 Component CCN: 14-S147	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/26/2022 11:09 am
		Title XIX	Subprovider - IPF	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)		0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		0	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)		0	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		326	15.00
16.00	Nursery days (title V or XIX only)		188	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)		0	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)		0	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)		0	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)		0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0147	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1	
				Component CCN: 14-S147		Date/Time Prepared: 5/26/2022 11:09 am	
				Title XIX		Subprovider - IPF	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)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0147

Period:

Worksheet D-1

Component CCN: 14-S147

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/26/2022 11:09 am

Title XIX

Subprovider -
IPF

PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0147	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/26/2022 11:09 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		1,826,280		30.00
31.00	03100	INTENSIVE CARE UNIT		1,372,840		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.268337	1,048,972	281,478	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.808299	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.130185	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.172289	482,592	83,145	54.00
56.00	05600	RADIOISOTOPE	0.141240	23,160	3,271	56.00
57.00	05700	CT SCAN	0.024498	1,377,204	33,739	57.00
58.00	05800	MRI	0.053434	7,780	416	58.00
60.00	06000	LABORATORY	0.133498	3,038,040	405,572	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.210080	1,827,374	383,895	65.00
66.00	06600	PHYSICAL THERAPY	0.219430	418,090	91,741	66.00
68.00	06800	SPEECH PATHOLOGY	0.510354	53,215	27,158	68.00
69.00	06900	ELECTROCARDIOLOGY	0.021965	481,670	10,580	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.389115	438,483	170,620	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.239181	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302712	3,343,743	1,012,191	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100	EMERGENCY	0.153669	1,181,400	181,545	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.298276	241,675	72,086	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		13,963,398	2,757,437	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)		13,963,398		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0147	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3
			Component CCN: 14-U147		Date/Time Prepared: 5/26/2022 11:09 am
			Title XVIII	Swing Beds - SNF	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.268337	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.808299	0	52.00
53.00	05300	ANESTHESIOLOGY	0.130185	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.172289	9,375	54.00
56.00	05600	RADIOISOTOPE	0.141240	0	56.00
57.00	05700	CT SCAN	0.024498	2,260	57.00
58.00	05800	MRI	0.053434	0	58.00
60.00	06000	LABORATORY	0.133498	91,785	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.210080	144,715	65.00
66.00	06600	PHYSICAL THERAPY	0.219430	385,655	66.00
68.00	06800	SPEECH PATHOLOGY	0.510354	30,145	68.00
69.00	06900	ELECTROCARDIOLOGY	0.021965	9,980	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.389115	2,548	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.239181	260,979	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302712	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
91.00	09100	EMERGENCY	0.153669	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.298276	3,760	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	93.99
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		941,202	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)		941,202	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0147	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/26/2022 11:09 am
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,583,031	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1,123,407	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)		122,924	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		35,612	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)		41.47	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)		4.52	30.00
31.00	Percentage of Medicaid patient days (see instructions)		19.95	31.00
32.00	Sum of lines 30 and 31		24.47	32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.88	33.00
34.00	Disproportionate share adjustment (see instructions)		100,816	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0147	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/26/2022 11:09 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		8,350,599,096	8,290,014,521
35.01	Factor 3 (see instructions)		0.000026433	0.000051886
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		220,731	430,139
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		165,095	108,419
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		273,514	
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges (see instructions)		0	
41.00	Total ESRD Medicare discharges (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	
43.00	Total Medicare ESRD inpatient days (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)		4,239,304	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		4,243,345	
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		4,243,345	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		274,614	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		297,980	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)		4,815,939	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		4,815,939	61.00
62.00	Deductibles billed to program beneficiaries		521,532	62.00
63.00	Coinsurance billed to program beneficiaries		4,081	63.00
64.00	Allowable bad debts (see instructions)		165,529	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		107,594	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		147,496	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		4,397,920	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)		9,656	70.93
70.94	HRR adjustment amount (see instructions)		-8,497	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0147	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/26/2022 11:09 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2019	615,463	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)	2020	326,535	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		57,591	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5,283,486	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		5,350,156	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-66,670	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		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	0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/26/2022 11:09 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,583,031	0	2,583,031		2,583,031
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,123,407	0		1,123,407	1,123,407
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	122,924	0	122,924		122,924
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	35,612	0		35,612	35,612
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	0.1088	0.1088	0.1088	0.1088	
11.00	Disproportionate share adjustment (see instructions)	34.00	100,816	0	70,259	30,557	100,816
11.01	Uncompensated care payments	36.00	273,514	0	165,247	108,267	273,514
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	4,239,304	0	2,941,461	1,297,843	4,239,304
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	4,243,345	0	2,958,019	1,285,326	4,243,345
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,243,345	0	2,958,019	1,285,326	4,243,345

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/26/2022 11:09 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	274,614	0	188,519	86,095	274,614
17.00	Special add-on payments for new technologies	54.00	297,980	0	0	297,980	297,980
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	3,146,538	1,669,401	4,815,939
		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	271,027	0	187,485	83,542	271,027
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	3,587	0	1,034	2,553	3,587
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	274,614	0	188,519	86,095	274,614
		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				0.195600	0.195600	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			615,463		615,463
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				326,535	326,535
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/26/2022 11:09 am

		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	2,583,031	2,583,031		2,583,031	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,123,407		1,123,407	1,123,407	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	122,924	122,924		122,924	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	35,612		35,612	35,612	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	0.1088	0.1088	0.1088		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	100,816	70,259	30,557	100,816	11.00
11.01	Uncompensated care payments	36.00	273,514	165,095	108,419	273,514	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	4,239,304	2,941,309	1,297,995	4,239,304	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	4,243,345	2,958,019	1,285,326	4,243,345	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,243,345	2,958,019	1,285,326	4,243,345	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	274,614	188,539	86,075	274,614	16.00
17.00	Special add-on payments for new technologies	54.00	297,980	0	297,980	297,980	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			3,146,558	1,669,381	4,815,939	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/26/2022 11:09 am

		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	271,027	187,485	83,542	271,027	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	3,587	1,054	2,533	3,587	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	274,614	188,539	86,075	274,614	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	615,463	615,463		615,463	28.00
29.00	Low volume adjustment on or after October 1	70.97	326,535		326,535	326,535	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	9,656	-17,603	27,259	9,656	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	-8,497	0	-8,497	-8,497	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		37,444	20,147	57,591	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0147	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 11:09 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		746	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)		4,811,956	2.00
3.00	OPPI payments		3,557,986	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		746	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		3,117	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		3,117	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		3,117	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,371	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)		746	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)		3,557,986	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		709,278	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,849,454	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,849,454	30.00
31.00	Primary payer payments		119	31.00
32.00	Subtotal (line 30 minus line 31)		2,849,335	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)		210,863	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		137,061	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		179,736	36.00
37.00	Subtotal (see instructions)		2,986,396	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)		2,986,396	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		2,934,955	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)		51,441	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: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part I
Date/Time Prepared:
5/26/2022 11:09 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		5,350,156		2,924,200	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	09/09/2011	10,755	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		10,755	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)		5,350,156		2,934,955	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		51,441	6.01	
6.02	SETTLEMENT TO PROGRAM		66,670		0	6.02	
7.00	Total Medicare program liability (see instructions)		5,283,486		2,986,396	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: 14-0147

Period:

Worksheet E-1

Component CCN: 14-U147

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
5/26/2022 11:09 am

		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		309,234		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)		309,234		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		2,631		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		311,865		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: 14-0147	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/26/2022 11:09 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-0147	Period: From 01/01/2021 To 12/31/2021	Worksheet E-2	
		Component CCN: 14-U147		Date/Time Prepared: 5/26/2022 11:09 am	
		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)		325,002	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		751	1,482	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)		325,002	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		325,002	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)		325,002	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		15,768	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		309,234	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)		4,048	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		2,631	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		2,464	0	18.00
19.00	Total (see instructions)		311,865	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		309,234	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)		2,631	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0147 Component CCN:14-S147	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part II Date/Time Prepared: 5/26/2022 11:09 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
	PART II - MEDICARE PART A SERVICES - IPF PPS			
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			0 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			0.000000 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			0 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			0 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			0 18.00
19.00	Deductibles			0 19.00
20.00	Subtotal (line 18 minus line 19)			0 20.00
21.00	Coinsurance			0 21.00
22.00	Subtotal (line 20 minus line 21)			0 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			0 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.98	Recovery of accelerated depreciation.			0 30.98
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			0 31.00
31.01	Sequestration adjustment (see instructions)			0 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			0 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			0 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000 99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.000000 99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0147 Component CCN: 14-5580	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VI Date/Time Prepared: 5/26/2022 11:09 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		0	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		0	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		0	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		0	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.98	Recovery of accelerated depreciation.		0	14.98
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		0	15.00
15.01	Sequestration adjustment (see instructions)		0	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)		0	15.75
16.00	Interim payments		0	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet G

Date/Time Prepared:
5/26/2022 11:09 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	3,551,168	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	35,620,411	0	0	0	4.00
5.00	Other receivable	593,340	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-27,847,239	0	0	0	6.00
7.00	Inventory	893,708	0	0	0	7.00
8.00	Prepaid expenses	239,268	0	0	0	8.00
9.00	Other current assets	24,335	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,074,991	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,005,119	0	0	0	12.00
13.00	Land improvements	607,816	0	0	0	13.00
14.00	Accumulated depreciation	458,471	0	0	0	14.00
15.00	Buildings	31,343,139	0	0	0	15.00
16.00	Accumulated depreciation	-21,226,154	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	129,811	0	0	0	21.00
22.00	Accumulated depreciation	-105,194	0	0	0	22.00
23.00	Major movable equipment	27,807,602	0	0	0	23.00
24.00	Accumulated depreciation	-20,386,425	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)	19,634,185	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	549,298	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	549,298	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	33,258,474	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	798,488	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,506,167	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	2,953,240	0	0	0	43.00
44.00	Other current liabilities	2,556,330	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,814,225	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	4,626,254	0	0	0	46.00
47.00	Notes payable	370,923	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,105,593	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	8,102,770	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,916,995	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	15,341,479				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)	15,341,479	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	33,258,474	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet G-1

Date/Time Prepared:
5/26/2022 11:09 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		7,837,142		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-7,793,194				2.00
3.00	Total (sum of line 1 and line 2)		43,948		0		3.00
4.00	RECONCILING ITEM	32,366,749		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)		32,366,749		0		10.00
11.00	Subtotal (line 3 plus line 10)		32,410,697		0		11.00
12.00	RECONCILING ITEM	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		32,410,697		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	RECONCILING ITEM		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	RECONCILING ITEM		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: 14-0147

Period:
From 01/01/2021
To 12/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
5/26/2022 11:09 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,500,918		4,500,918	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,344,294		1,344,294	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,845,212		5,845,212	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,810,371		2,810,371	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)	2,810,371		2,810,371	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,655,583		8,655,583	17.00
18.00	Ancillary services	29,732,364	125,531,798	155,264,162	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	1,888,549	1,888,549	20.00
20.01	RURAL HEALTH CLINIC II	0	2,285,189	2,285,189	20.01
20.02	RURAL HEALTH CLINIC III	0	4,007,160	4,007,160	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY	0	0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	PHYS PRIVATE OFFICES AND PRO FEE	0	30,438,211	30,438,211	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	38,387,947	164,150,907	202,538,854	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		63,494,915		29.00
30.00	BAD DEBTS	2,109,984			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)		2,109,984		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)		65,604,899		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0147

Period:
From 01/01/2021
To 12/31/2021

Worksheet G-3

Date/Time Prepared:
5/26/2022 11:09 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	202,538,854	1.00
2.00	Less contractual allowances and discounts on patients' accounts	147,166,892	2.00
3.00	Net patient revenues (line 1 minus line 2)	55,371,962	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	65,604,899	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-10,232,937	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	486,707	24.00
24.50	COVID-19 PHE Funding	1,953,036	24.50
25.00	Total other income (sum of lines 6-24)	2,439,743	25.00
26.00	Total (line 5 plus line 25)	-7,793,194	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-7,793,194	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0147	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 5/26/2022 11:09 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		271,027	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		3,587	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)		10.01	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)		274,614	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: 14-0147

Period:

Worksheet M-1

Component CCN: 14-8548

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/26/2022 11:09 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	538,043	0	538,043	0	538,043
2.00	Physician Assistant	35,430	0	35,430	0	35,430
3.00	Nurse Practitioner	49,800	0	49,800	0	49,800
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	146,278	0	146,278	0	146,278
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)	769,551	0	769,551	0	769,551
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	34,540	34,540	0	34,540
16.00	Transportation (Health Care Staff)	0	3,667	3,667	0	3,667
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	30,666	30,666	0	30,666
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	68,873	68,873	0	68,873
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	769,551	68,873	838,424	0	838,424
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	29,037	29,037	0	29,037
30.00	Administrative Costs	165,611	171,108	336,719	104,098	440,817
31.00	Total Facility Overhead (sum of lines 29 and 30)	165,611	200,145	365,756	104,098	469,854
32.00	Total facility costs (sum of lines 22, 28 and 31)	935,162	269,018	1,204,180	104,098	1,308,278

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0147

Period:

Worksheet M-1

Component CCN: 14-8548

From 01/01/2021

Date/Time Prepared:

To 12/31/2021

5/26/2022 11:09 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	538,043	1.00
2.00	Physician Assistant	0	35,430	2.00
3.00	Nurse Practitioner	0	49,800	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	146,278	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	769,551	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	34,540	15.00
16.00	Transportation (Health Care Staff)	0	3,667	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	30,666	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	68,873	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	838,424	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	29,037	29.00
30.00	Administrative Costs	76,212	517,029	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	76,212	546,066	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	76,212	1,384,490	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0147

Period:

Worksheet M-1

Component CCN: 14-8586

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/26/2022 11:09 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	862,148	0	862,148	0	862,148
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	10,129	0	10,129	0	10,129
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
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)	872,277	0	872,277	0	872,277
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	48,372	48,372	0	48,372
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	11,887	11,887	0	11,887
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	60,259	60,259	0	60,259
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	872,277	60,259	932,536	0	932,536
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	2,533	2,533	0	2,533
30.00	Administrative Costs	9,372	122,432	131,804	33,227	165,031
31.00	Total Facility Overhead (sum of lines 29 and 30)	9,372	124,965	134,337	33,227	167,564
32.00	Total facility costs (sum of lines 22, 28 and 31)	881,649	185,224	1,066,873	33,227	1,100,100

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0147

Period:

Worksheet M-1

Component CCN: 14-8586

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/26/2022 11:09 am

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	862,148	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	10,129	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory 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	872,277	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	48,372	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	11,887	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	60,259	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	932,536	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	2,533	29.00
30.00	Administrative Costs	92,218	257,249	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	92,218	259,782	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	92,218	1,192,318	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0147

Period:

Worksheet M-1

Component CCN: 14-8584

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/26/2022 11:09 am

		RHC III		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0
2.00	Physician Assistant	38,667	0	38,667	0	38,667
3.00	Nurse Practitioner	834,880	0	834,880	0	834,880
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	366,304	0	366,304	0	366,304
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)	1,239,851	0	1,239,851	0	1,239,851
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	55,484	55,484	0	55,484
16.00	Transportation (Health Care Staff)	0	106	106	0	106
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	21,108	21,108	0	21,108
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	76,698	76,698	0	76,698
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,239,851	76,698	1,316,549	0	1,316,549
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	280,298	280,298	0	280,298
30.00	Administrative Costs	583,577	508,390	1,091,967	300,514	1,392,481
31.00	Total Facility Overhead (sum of lines 29 and 30)	583,577	788,688	1,372,265	300,514	1,672,779
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,823,428	865,386	2,688,814	300,514	2,989,328

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0147

Period:

Worksheet M-1

Component CCN: 14-8584

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/26/2022 11:09 am

		RHC III		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	38,667	2.00
3.00	Nurse Practitioner	0	834,880	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	366,304	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	1,239,851	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	55,484	15.00
16.00	Transportation (Health Care Staff)	0	106	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	21,108	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	76,698	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,316,549	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	280,298	29.00
30.00	Administrative Costs	161,707	1,554,188	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	161,707	1,834,486	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	161,707	3,151,035	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0147

Period:

Worksheet M-2

Component CCN: 14-8548

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/26/2022 11:09 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.00	5,494	4,200	4,200		1.00
2.00	Physician Assistant	0.29	0	2,100	609		2.00
3.00	Nurse Practitioner	0.33	0	2,100	693		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.62	5,494		5,502	5,502	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)	1.62	5,494			5,502	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)					838,424	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					838,424	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					546,066	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					827,020	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,373,086	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,373,086	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,373,086	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,211,510	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0147

Period:

Worksheet M-2

Component CCN: 14-8586

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/26/2022 11:09 am

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	2.37	6,333	2,800	6,636		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	0.00	0	1,400	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.37	6,333		6,636	6,636	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)	2.37	6,333			6,636	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)					932,536	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					932,536	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					259,782	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					682,302	15.00
16.00	Total overhead (sum of lines 14 and 15)					942,084	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					942,084	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					942,084	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,874,620	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0147

Period:

Worksheet M-2

Component CCN: 14-8584

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/26/2022 11:09 am

		RHC III		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.33	15,124	4,200	5,586	1.00
2.00	Physician Assistant	0.20	0	0	0	2.00
3.00	Nurse Practitioner	5.53	0	2,100	11,613	3.00
4.00	Subtotal (sum of lines 1 through 3)	7.06	15,124		17,199	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)	7.06	15,124		17,199	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)				1,316,549	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,316,549	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				1,834,486	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,963,163	15.00
16.00	Total overhead (sum of lines 14 and 15)				3,797,649	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				3,797,649	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				3,797,649	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				5,114,198	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0147 Component CCN: 14-8548	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/26/2022 11:09 am	
			Title XVIII	RHC I	Cost
					1.00
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,211,510	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			120,175	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,091,335	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,502	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)			5,502	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			380.10	7.00
			Calculation of Limit (1)		
			Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		400.00	400.00	8.00
9.00	Rate for Program covered visits (see instructions)		380.10	380.10	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	2,297	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	873,090	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		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	873,090	16.00
16.01	Total program charges (see instructions)(from contractor's records)			571,422	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			652,386	16.04
16.05	Total program cost (see instructions)		0	652,386	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			57,608	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			100,593	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			652,386	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			76,704	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			729,090	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			729,090	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			525,374	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)			203,716	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0147 Component CCN: 14-8586	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/26/2022 11:09 am	
			Title XVIII	RHC II	Cost
					1.00
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,874,620	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			37,936	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,836,684	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,636	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)			6,636	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			276.78	7.00
			Calculation of Limit (1)		
			Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		400.00	400.00	8.00
9.00	Rate for Program covered visits (see instructions)		276.78	276.78	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	77	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	21,312	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		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	21,312	16.00
16.01	Total program charges (see instructions)(from contractor's records)			17,500	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			17,050	16.04
16.05	Total program cost (see instructions)		0	17,050	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			3,510	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			17,050	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			18,997	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			36,047	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			36,047	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			23,442	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)			12,605	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0147 Component CCN: 14-8584	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/26/2022 11:09 am	
			Title XVIII	RHC III	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)			5,114,198	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			94,274	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			5,019,924	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			17,199	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)			17,199	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			291.87	7.00
			Calculation of Limit (1)		
			Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		400.00	400.00	8.00
9.00	Rate for Program covered visits (see instructions)		291.87	291.87	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	3,983	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	1,162,518	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		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	1,162,518	16.00
16.01	Total program charges (see instructions)(from contractor's records)			1,081,428	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			876,710	16.04
16.05	Total program cost (see instructions)		0	876,710	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			66,631	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			199,137	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			876,710	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			50,545	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			927,255	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			927,255	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			800,663	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)			126,592	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: 14-0147

Period:

Worksheet M-4

Component CCN: 14-8548

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/26/2022 11:09 am

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	769,551	769,551	769,551	769,551	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.035085	0.008600	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	27,000	6,618	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2,811	9,132	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	29,811	15,750	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	838,424	838,424	838,424	838,424	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,373,086	1,373,086	1,373,086	1,373,086	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.035556	0.018785	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	48,821	25,793	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	78,632	41,543	0	0	10.00
11.00	Total number of injections/infusions (from your records)	203	101	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	387.35	411.32	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	129	65	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)	49,968	26,736	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)		120,175			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)		76,704			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0147

Period:

Worksheet M-4

Component CCN: 14-8586

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/26/2022 11:09 am

		Title XVIII		RHC II	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	872,277	872,277	872,277	872,277	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.007340	0.001520	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	6,403	1,326	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	5,247	5,896	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	11,650	7,222	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	932,536	932,536	932,536	932,536	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	942,084	942,084	942,084	942,084	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.012493	0.007744	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	11,769	7,295	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	23,419	14,517	0	0	10.00
11.00	Total number of injections/infusions (from your records)	87	180	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	269.18	80.65	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	52	62	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	13,997	5,000	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)		37,936			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)		18,997			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0147

Period:

Worksheet M-4

Component CCN: 14-8584

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/26/2022 11:09 am

		Title XVIII		RHC III	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)	1,239,851	1,239,851	1,239,851	1,239,851	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.003120	0.005470	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	3,868	6,782	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	8,058	5,560	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	11,926	12,342	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,316,549	1,316,549	1,316,549	1,316,549	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	3,797,649	3,797,649	3,797,649	3,797,649	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.009059	0.009375	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	34,403	35,603	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	46,329	47,945	0	0	10.00
11.00	Total number of injections/infusions (from your records)	81	142	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	571.96	337.64	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	50	65	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)	28,598	21,947	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)		94,274			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)		50,545			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0147 Component CCN: 14-8548	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/26/2022 11:09 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		505,235	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		09/09/2021	20,139	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		20,139	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		525,374	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		203,716	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		729,090	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0147 Component CCN: 14-8586	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/26/2022 11:09 am	
			RHC II	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		18,051	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		09/09/2021	5,391		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		5,391		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		23,442		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		12,605		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		36,047		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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0147 Component CCN: 14-8584	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/26/2022 11:09 am	
			RHC III	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		549,609	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		09/09/2021	251,054	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		251,054	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		800,663	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		126,592	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		927,255	7.00	
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00