

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0210	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/29/2021 2:19 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/29/2021	Time: 2:19 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status	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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARRISBURG MEDICAL CENTER, INC. (14-0210) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) JUNE HAYES
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	24,608	-4,062	0	0	1.00
2.00 Subprovider - IPF	0	-2,555	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		189,978		0	10.00
10.01 RURAL HEALTH CLINIC II	0		74,606		0	10.01
10.02 RURAL HEALTH CLINIC III	0		86,820		0	10.02
200.00 Total	0	22,053	347,342	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: 14-0210		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 2:19 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 100 DR WARREN TUTTLE DRIVE			PO Box:				1.00		
2.00	City: HARRISBURG			State: IL		Zip Code: 62946		County: SALINE		
		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		HARRISBURG MEDICAL CENTER, INC.	140210	99914	1	07/01/1966	N	P	N
4.00	Subprovider - IPF		HARRISBURG MEDICAL CENTER, INC.	14S210	99914	4	06/19/1989	N	P	N
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		HARRISBURG MEDICAL CENTER, INC.	14U210	99914		11/03/1988	N	P	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		ELDORADO PRIMARY CARE	143473	99914		12/31/2001	N	O	N
15.01	Hospital-Based Health Clinic - RHC		HMC AT HARRISBURG	148589	99914		06/05/2018	N	O	N
15.02	Hospital-Based Health Clinic - RHC		HMC AT MARION	148590	99914		06/05/2018	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020	06/30/2021		20.00
21.00	Type of Control (see instructions)						2			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/29/2021 2:19 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	41	14	0	4	222	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural St	Date of Geogra	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					1		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					07/01/2020	06/30/2021	36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					Y	Y	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	Y	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0210		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 2:19 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count
			1.00		2.00	3.00	4.00
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					0.00	0.00
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					0.00	0.00
						1.00	
62.00	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
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	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. 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/29/2021 2:19 pm

	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		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	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)				N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0210	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 2:19 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0210	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 2:19 pm
		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
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	164,829	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0210		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 2:19 pm		
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:						
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.								N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.									146.00
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital	N	N	N	N	N	155.00			
156.00	Subprovider - IPF	N	N	N	N	N	156.00			
157.00	Subprovider - IRF	N	N	N	N	N	157.00			
158.00	SUBPROVIDER						158.00			
159.00	SNF	N	N	N	N	N	159.00			
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00			
161.00	CMHC		N	N	N	N	161.00			
								1.00		
165.00	Multicampus Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00			
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0210		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part II Date/Time Prepared: 11/29/2021 2:19 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A	12/31/2021	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			Y			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	11/02/2021	Y	11/02/2021
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: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/29/2021 2:19 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		Y		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer	CLIFTONLARSENALLEN LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0210	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/29/2021 2:19 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 2:19 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	38	13,870	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		38	13,870	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						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)		38	13,870	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	30	10,950		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 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)		68				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 2:19 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,195	41	1,874			1.00
2.00	HMO and other (see instructions)	231	240				2.00
3.00	HMO IPF Subprovider	128	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	207	0	286			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	15			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,402	41	2,175			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)	1,402	41	2,175	0.00	340.85	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,855	3,061	6,052	0.00	55.46	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	4,106	0	13,539	0.00	15.61	26.00
26.01	RURAL HEALTH CLINIC II	3,276	0	13,299	0.00	12.39	26.01
26.02	RURAL HEALTH CLINIC III	3,809	0	14,603	0.00	14.79	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	439.10	27.00
28.00	Observation Bed Days		0	1,262			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 2:19 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	436	101	722	1.00
2.00 HMO and other (see instructions)			60	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	436	101	722	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	175	425	781	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 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: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/29/2021 2:19 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on 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	23,760,009	0	23,760,009	921,669.20	25.78
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		547,565	0	547,565	4,461.50	122.73
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		2,637,140	0	2,637,140	22,545.74	116.97
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		1,238,992	-206	1,238,786	70,317.05	17.62
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		3,410,093	0	3,410,093	132,762.46	25.69
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		759,606	0	759,606	9,198.29	82.58
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		9,800	0	9,800	60.00	163.33
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,204,854	0	5,204,854		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,022,324	0	1,022,324		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		70,238	0	70,238		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		347,820	0	347,820		
24.00	Wage-related costs (RHC/FQHC)		484,748	0	484,748		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/29/2021 2:19 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on 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	
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	339,016	0	339,016	12,940.26	26.20
27.00	Administrative & General	5.00	3,498,499	0	3,498,499	143,751.87	24.34
28.00	Administrative & General under contract (see inst.)		725,340	0	725,340	2,773.82	261.49
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	446,272	0	446,272	26,158.55	17.06
31.00	Laundry & Linen Service	8.00	48,173	0	48,173	3,719.50	12.95
32.00	Housekeeping	9.00	564,347	0	564,347	42,635.58	13.24
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	611,750	0	611,750	40,599.42	15.07
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	62,773	0	62,773	4,414.75	14.22
39.00	Central Services and Supply	14.00	271,898	0	271,898	20,517.04	13.25
40.00	Pharmacy	15.00	550,151	0	550,151	11,875.80	46.33
41.00	Medical Records & Medical Records Library	16.00	580,652	0	580,652	29,140.99	19.93
42.00	Social Service	17.00	0	0	0	0.00	0.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part III
Date/Time Prepared:
11/29/2021 2:19 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on 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)	20,061,652	206	20,061,858	827,118.73	24.26	1.00
2.00	Excluded area salaries (see instructions)	3,410,093	0	3,410,093	132,762.46	25.69	2.00
3.00	Subtotal salaries (line 1 minus line 2)	16,651,559	206	16,651,765	694,356.27	23.98	3.00
4.00	Subtotal other wages & related costs (see inst.)	769,406	0	769,406	9,258.29	83.10	4.00
5.00	Subtotal wage-related costs (see inst.)	5,204,854	0	5,204,854	0.00	31.26	5.00
6.00	Total (sum of lines 3 thru 5)	22,625,819	206	22,626,025	703,614.56	32.16	6.00
7.00	Total overhead cost (see instructions)	7,698,871	0	7,698,871	338,527.58	22.74	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0210	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 11/29/2021 2:19 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		693,884	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		4,298,777	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		83,314	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		23,356	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		263,793	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		1,371,424	17.00
18.00	Medicare Taxes - Employers Portion Only		320,736	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		55,248	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		19,452	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		7,129,984	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: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part V
Date/Time Prepared:
11/29/2021 2:19 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	933,260	7,129,984	1.00
2.00	Hospital	759,606	5,272,029	2.00
3.00	Subprovider - IPF	173,654	791,719	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	380,511	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	357,897	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	327,828	14.02
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0210 Component CCN: 14-3473		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 11/29/2021 2:19 pm		
				RHC I		Cost				
				1.00						
Clinic Address and Identification										
1.00	Street				1007 USE ROUTE 45			1.00		
				City		State		ZIP Code		
				1.00		2.00		3.00		
2.00	City, State, ZIP Code, County				ELDORADO IL 62930			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		20:00		08:00	
						1.00		2.00		
12.00	Have you received an approval for an exception to the productivity standard?				N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00	
				Provider name		CCN number				
				1.00		2.00				
14.00	RHC/FQHC name, CCN number								14.00	
				Y/N		V		XVIII		
				1.00		2.00		3.00		
								XIX		
								Total Visits		
								5.00		
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00	
				County						
				4.00						
2.00	City, State, ZIP Code, County				SALINE				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				20:00		08:00		20:00	
								08:00		
								17:00		
								11.00		

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0210

Period:

Worksheet S-8

Component CCN: 14-3473

From 07/01/2020

To 06/30/2021

Date/Time Prepared:

11/29/2021 2:19 pm

		RHC I		Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
11.00	Facility hours of operations (1)				
	CLINIC	08:00	16:50		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0210

Period:

Worksheet S-8

Component CCN: 14-8589

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 2:19 pm

		RHC II		Cost		
		1.00				
1.00	Clinic Address and Identification					
	Street					1.00
	City		State	ZIP Code		
	1.00		2.00	3.00		
2.00	City, State, ZIP Code, County		HARRISBURG IL 62946		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		
		from	to	from	to	
		1.00	2.00	3.00	4.00	
		Tuesday		from		
		1.00		5.00		
Facility hours of operations (1)						
11.00	CLINIC		07:30	16:30	07:30	
					1.00	
					2.00	
12.00	Have you received an approval for an exception to the productivity standard?					N 12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.					N 0 13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00
		Y/N	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	
		Total Visits				
		5.00				
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00
			County			
			4.00			
2.00	City, State, ZIP Code, County		SALINE			
		Tuesday	Wednesday		Thursday	
		to	from	to	from	
		6.00	7.00	8.00	9.00	
		to		10.00		
Facility hours of operations (1)						
11.00	CLINIC	16:30	07:30	16:30	07:30	
					16:30	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0210

Period:

Worksheet S-8

Component CCN: 14-8589

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 2:19 pm

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)						
	CLINIC	07:30	16:30	09:00	13:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0210 Component CCN: 14-8590		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 11/29/2021 2:19 pm	
				RHC III		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			3106 OUTER DRIVE			1.00		
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			MARION IL 62959		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			07:30		16:30		07:30	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			WILLIAMSON				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			16:30		07:30		16:30	
				07:30		16:30		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0210

Period:

Worksheet S-8

Component CCN: 14-8590

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 2:19 pm

RHC III

Cost

		Friday		Saturday				
		from	to	from	to			
		11.00	12.00	13.00	14.00			
11.00	Facility hours of operations (1)							
	CLINIC	07:30	16:30				11.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0210	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/29/2021 2:19 pm	
			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.394838	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		8,135,054	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		2,478,953	5.00	
6.00	Medicaid charges		27,767,335	6.00	
7.00	Medicaid cost (line 1 times line 6)		10,963,599	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)		349,592	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		45,973	9.00	
10.00	Stand-alone CHIP charges		85,611	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		33,802	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)		349,592	19.00	
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	729,265	1,450,731	2,179,996	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	287,942	1,450,731	1,738,673	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	287,942	1,450,731	1,738,673	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,407,458	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		467,112	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		718,633	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		1,688,825	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		918,333	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,657,006	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,006,598	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0210

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

Worksheet A

Date/Time Prepared:
11/29/2021 2:19 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (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		2,896,902	2,896,902	-347,595	2,549,307	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,557,471	1,557,471	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	339,016	7,405,460	7,744,476	0	7,744,476	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,498,499	4,863,866	8,362,365	-101,435	8,260,930	5.00
7.00	00700	OPERATION OF PLANT	446,272	709,805	1,156,077	62,249	1,218,326	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	48,173	74,385	122,558	0	122,558	8.00
9.00	00900	HOUSEKEEPING	564,347	89,737	654,084	0	654,084	9.00
10.00	01000	DIETARY	611,750	251,303	863,053	0	863,053	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	62,773	138,290	201,063	0	201,063	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	271,898	108,915	380,813	0	380,813	14.00
15.00	01500	PHARMACY	550,151	326,627	876,778	0	876,778	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	580,652	212,315	792,967	0	792,967	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	547,565	547,565	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,514,363	2,100,135	4,614,498	0	4,614,498	30.00
40.00	04000	SUBPROVIDER - IPF	2,638,330	1,244,492	3,882,822	0	3,882,822	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	597,991	260,747	858,738	0	858,738	50.00
53.00	05300	ANESTHESIOLOGY	844,130	33,886	878,016	-547,565	330,451	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	627,560	192,839	820,399	206	820,605	54.00
54.01	05401	ULTRASOUND	185,037	27,322	212,359	0	212,359	54.01
54.02	03440	MAMMOGRAPHY	72,653	64,267	136,920	0	136,920	54.02
56.00	05600	RADIOISOTOPE	76,521	229,838	306,359	0	306,359	56.00
57.00	05700	CT SCAN	208,423	137,056	345,479	0	345,479	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	74,058	28,106	102,164	0	102,164	58.00
60.00	06000	LABORATORY	1,008,477	1,797,380	2,805,857	0	2,805,857	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	598,144	194,475	792,619	0	792,619	65.00
66.00	06600	PHYSICAL THERAPY	620,152	14,166	634,318	0	634,318	66.00
67.00	06700	OCCUPATIONAL THERAPY	217,760	6,322	224,082	0	224,082	67.00
68.00	06800	SPEECH PATHOLOGY	56,309	417	56,726	0	56,726	68.00
69.00	06900	ELECTROCARDIOLOGY	131,145	53,022	184,167	0	184,167	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,407,801	1,407,801	-589,048	818,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	589,048	589,048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,903,431	1,903,431	0	1,903,431	73.00
75.00	07500	ASC (NON-DISTINCT PART)	598,362	88,858	687,220	0	687,220	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	87,276	4,493	91,769	0	91,769	76.00
76.97	07697	CARDIAC REHABILITATION	99,214	20,699	119,913	0	119,913	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,268,017	534,101	1,802,118	-38,917	1,763,201	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,192,659	554,193	1,746,852	-18,480	1,728,372	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,092,455	1,308,199	2,400,654	-193,767	2,206,887	88.02
91.00	09100	EMERGENCY	1,205,679	1,916,474	3,122,153	0	3,122,153	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		898,299	898,299	-898,299	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,988,246	32,098,623	55,086,869	21,433	55,108,302	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	640,651	132,255	772,906	-12,612	760,294	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	38,353	615	38,968	0	38,968	194.01
194.02	07952	FOUNDATION	92,759	83,662	176,421	-8,821	167,600	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	23,760,009	32,315,155	56,075,164	0	56,075,164	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0210

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

Worksheet A

Date/Time Prepared:
11/29/2021 2:19 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-62,884	2,486,423	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,557,471	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-261,517	7,482,959	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-359,809	7,901,121	5.00
7.00	00700	OPERATION OF PLANT	34	1,218,360	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	122,558	8.00
9.00	00900	HOUSEKEEPING	0	654,084	9.00
10.00	01000	DIETARY	-80,864	782,189	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	201,063	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	380,813	14.00
15.00	01500	PHARMACY	-286,021	590,757	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-37,283	755,684	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-547,565	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,459,491	3,155,007	30.00
40.00	04000	SUBPROVIDER - IPF	-753,249	3,129,573	40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	75	858,813	50.00
53.00	05300	ANESTHESIOLOGY	-296,565	33,886	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	820,605	54.00
54.01	05401	ULTRASOUND	0	212,359	54.01
54.02	03440	MAMMOGRAPHY	0	136,920	54.02
56.00	05600	RADIOISOTOPE	0	306,359	56.00
57.00	05700	CT SCAN	14	345,493	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	102,164	58.00
60.00	06000	LABORATORY	-2,291	2,803,566	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-98,393	694,226	65.00
66.00	06600	PHYSICAL THERAPY	147	634,465	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	224,082	67.00
68.00	06800	SPEECH PATHOLOGY	0	56,726	68.00
69.00	06900	ELECTROCARDIOLOGY	-12,095	172,072	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	818,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	589,048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,903,431	73.00
75.00	07500	ASC (NON-DISTINCT PART)	100	687,320	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	91,769	76.00
76.97	07697	CARDIAC REHABILITATION	-17,661	102,252	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	1,763,201	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,728,372	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,206,887	88.02
91.00	09100	EMERGENCY	-1,600,737	1,521,416	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,876,055	49,232,247	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	760,294	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	194.00
194.01	07951	AUXILIARY	0	38,968	194.01
194.02	07952	FOUNDATION	0	167,600	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,876,055	50,199,109	200.00

RECLASSIFICATIONS

Provider CCN: 14-0210

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

Worksheet A-6

Date/Time Prepared:
11/29/2021 2:19 pm

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
		A - INTEREST EXP & BOND AMORT				
1.00		CAP REL COSTS-BLDG & FIXT	1.00	0	898,299	1.00
		0		0	898,299	
		B - MME DEPRECIATION				
1.00		CAP REL COSTS-MVBLE EQUIP	2.00	0	1,513,622	1.00
		0		0	1,513,622	
		D - PROPERTY INSURANCE				
1.00		OTHER CAP REL COSTS	3.00	0	137,164	1.00
		0		0	137,164	
		G - RADIOLOGY TECHS				
1.00		RADIOLOGY-DIAGNOSTIC	54.00	206	0	1.00
		0		206	0	
		I - IMPLANTABLE DEVICES				
1.00		IMPL. DEV. CHARGED TO	72.00	0	589,048	1.00
		PATIENTS		0	589,048	
		0		0	589,048	
		J - CRNA SALARIES				
1.00		NONPHYSICIAN ANESTHETISTS	19.00	547,565	0	1.00
		0		547,565	0	
		L - ALLOWABLE ADVERTISING				
1.00		ADMINISTRATIVE & GENERAL	5.00	0	8,821	1.00
		0		0	8,821	
		M - OVERHEAD COSTS				
1.00		CAP REL COSTS-BLDG & FIXT	1.00	0	174,413	1.00
2.00		ADMINISTRATIVE & GENERAL	5.00	0	35,519	2.00
3.00		OPERATION OF PLANT	7.00	0	62,249	3.00
4.00			0.00	0	0	4.00
5.00			0.00	0	0	5.00
		0		0	272,181	
500.00		Grand Total: Increases		547,771	3,419,135	500.00

RECLASSIFICATIONS

Provider CCN: 14-0210

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

Worksheet A-6

Date/Time Prepared:
11/29/2021 2:19 pm

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00			10.00
	A - INTEREST EXP & BOND AMORT						
1.00	INTEREST EXPENSE	113.00	0	898,299	11	1.00	
	0		0	898,299			
	B - MME DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,513,622	9	1.00	
	0		0	1,513,622			
	D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	137,164	12	1.00	
	0		0	137,164			
	G - RADIOLOGY TECHS						
1.00	RURAL HEALTH CLINIC	88.00	206	0	0	1.00	
	0		206	0			
	I - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	589,048	0	1.00	
	0		0	589,048			
	J - CRNA SALARIES						
1.00	ANESTHESIOLOGY	53.00	547,565	0	0	1.00	
	0		547,565	0			
	L - ALLOWABLE ADVERTISING						
1.00	FOUNDATION	194.02	0	8,821	0	1.00	
	0		0	8,821			
	M - OVERHEAD COSTS						
1.00	RURAL HEALTH CLINIC	88.00	0	38,711	10	1.00	
2.00	RURAL HEALTH CLINIC II	88.01	0	18,480	0	2.00	
3.00	RURAL HEALTH CLINIC III	88.02	0	193,767	0	3.00	
4.00	ADMINISTRATIVE & GENERAL	5.00	0	8,611	0	4.00	
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	12,612	0	5.00	
	0		0	272,181			
500.00	Grand Total: Decreases		547,771	3,419,135		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/29/2021 2:19 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	772,443	0	0	0	0	1.00	
2.00	Land Improvements	688,854	0	0	0	16,765	2.00	
3.00	Buildings and Fixtures	38,304,995	202,061	0	202,061	219,933	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	18,686,455	1,656,748	0	1,656,748	1,720,016	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	58,452,747	1,858,809	0	1,858,809	1,956,714	8.00	
9.00	Reconciling Items	-2,686,801	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	61,139,548	1,858,809	0	1,858,809	1,956,714	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	772,443	0				1.00	
2.00	Land Improvements	672,089	0				2.00	
3.00	Buildings and Fixtures	38,287,123	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	18,623,187	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	58,354,842	0				8.00	
9.00	Reconciling Items	-2,686,801	0				9.00	
10.00	Total (line 8 minus line 9)	61,041,643	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/29/2021 2:19 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,896,902	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)	2,896,902	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	2,896,902				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2,896,902				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/29/2021 2:19 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	39,731,655	0	39,731,655	0.680320	93,315	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	18,669,734	0	18,669,734	0.319680	43,849	2.00
3.00	Total (sum of lines 1-2)	58,401,389	0	58,401,389	1.000000	137,164	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	93,315	1,383,280	174,413	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	43,849	1,513,622	0	2.00
3.00	Total (sum of lines 1-2)	0	0	137,164	2,896,902	174,413	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	835,415	93,315	0	0	2,486,423	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	43,849	0	0	1,557,471	2.00
3.00	Total (sum of lines 1-2)	835,415	137,164	0	0	4,043,894	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0210

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

Worksheet A-8

Date/Time Prepared:
11/29/2021 2:19 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-62,884	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	-475	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	-6,906	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	-4,242,769			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-80,864	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-37,283	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	-4,219	ADMINISTRATIVE & GENERAL	5.00	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	A	-547,565	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
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	MISC INCOME - A&G	B	-174,336	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	CREDENTIALLING INCOME	B	-3,363	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISC INCOME - LAB	B	0	LABORATORY	60.00	0	33.02

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0210

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

Worksheet A-8

Date/Time Prepared:
11/29/2021 2:19 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
34.00 RENTAL INCOME	A	-13,000	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00 CRNA BENEFITS	A	-164,315	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
35.01 PHYSICIAN BENEFITS	A	-96,927	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.01
36.00 340B RETAIL PHARMACY	A	-286,021	PHARMACY	15.00	0	36.00
37.00 CAPITALIZED INTEREST	A	34	OPERATION OF PLANT	7.00	0	37.00
37.01 CAPITALIZED INTEREST	A	75	OPERATING ROOM	50.00	0	37.01
37.02 CAPITALIZED INTEREST	A	14	CT SCAN	57.00	0	37.02
37.03 CAPITALIZED INTEREST	A	147	PHYSICAL THERAPY	66.00	0	37.03
37.04 CAPITALIZED INTEREST	A	100	ASC (NON-DISTINCT PART)	75.00	0	37.04
37.05 CAPITALIZED INTEREST	A	87	EMERGENCY	91.00	0	37.05
38.00 INSURANCE SETTLEMENTS	A	-589	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00 COMM RELATIONS - A&G	A	-3,801	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00 PHYSICIAN RECRUITMENT	A	-29,600	ADMINISTRATIVE & GENERAL	5.00	0	40.00
40.01 PHYSICIAN LOANS	A	-53,472	ADMINISTRATIVE & GENERAL	5.00	0	40.01
40.02 LOBBYING DUES	A	-18,890	ADMINISTRATIVE & GENERAL	5.00	0	40.02
40.03 HR DUES	A	-275	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.03
40.04 ADMIN DUES	A	-48,958	ADMINISTRATIVE & GENERAL	5.00	0	40.04
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,876,055				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0210

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

Worksheet A-8-2

Date/Time Prepared:
11/29/2021 2:19 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	2,200	2,200	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,459,491	1,459,491	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	809,295	652,599	156,696	181,300	643	3.00
4.00	53.00	ANESTHESIOLOGY	296,565	296,565	0	0	0	4.00
5.00	60.00	LABORATORY	9,800	0	9,800	260,300	60	5.00
6.00	65.00	RESPIRATORY THERAPY	98,393	98,393	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	12,095	12,095	0	0	0	7.00
8.00	76.97	CARDIAC REHABILITATION	17,661	17,661	0	0	0	8.00
9.00	91.00	EMERGENCY	1,600,824	1,600,824	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,306,324	4,139,828	166,496		703	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	56,046	2,802	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	7,509	375	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			63,555	3,177	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	2,200		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,459,491		2.00
3.00	40.00	SUBPROVIDER - IPF	0	56,046	100,650	753,249		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	296,565		4.00
5.00	60.00	LABORATORY	0	7,509	2,291	2,291		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	98,393		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	12,095		7.00
8.00	76.97	CARDIAC REHABILITATION	0	0	0	17,661		8.00
9.00	91.00	EMERGENCY	0	0	0	1,600,824		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	63,555	102,941	4,242,769		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
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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	2,486,423	2,486,423			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,557,471		1,557,471		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,482,959	29,991	2,684	7,515,634	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,901,121	243,266	272,813	1,165,991	5.00
7.00	00700	OPERATION OF PLANT	1,218,360	48,646	13,457	148,734	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	122,558	3,520	6,444	16,055	8.00
9.00	00900	HOUSEKEEPING	654,084	8,799	1,175	188,086	9.00
10.00	01000	DIETARY	782,189	43,088	7,227	203,885	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	201,063	9,781	68	20,921	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	380,813	94,976	20,131	90,618	14.00
15.00	01500	PHARMACY	590,757	15,487	116,680	183,355	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	755,684	12,208	1,620	193,520	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,155,007	174,280	96,126	829,179	30.00
40.00	04000	SUBPROVIDER - IPF	3,129,573	268,052	13,369	879,305	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	858,813	129,247	186,189	199,299	50.00
53.00	05300	ANESTHESIOLOGY	33,886	0	12,365	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	820,605	40,273	120,690	209,222	54.00
54.01	05401	ULTRASOUND	212,359	9,244	67,554	61,669	54.01
54.02	03440	MAMMOGRAPHY	136,920	5,706	7,330	24,214	54.02
56.00	05600	RADIOISOTOPE	306,359	34,604	1,948	25,503	56.00
57.00	05700	CT SCAN	345,493	9,744	48,096	69,463	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	102,164	279,796	210,604	24,682	58.00
60.00	06000	LABORATORY	2,803,566	53,240	136,026	336,106	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	694,226	24,545	16,035	199,350	65.00
66.00	06600	PHYSICAL THERAPY	634,465	61,928	7,912	206,685	66.00
67.00	06700	OCCUPATIONAL THERAPY	224,082	3,557	0	72,575	67.00
68.00	06800	SPEECH PATHOLOGY	56,726	0	0	18,767	68.00
69.00	06900	ELECTROCARDIOLOGY	172,072	30,455	8,052	43,708	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	818,753	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	589,048	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,903,431	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	687,320	101,979	53,417	199,423	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	91,769	20,692	10,551	29,087	76.00
76.97	07697	CARDIAC REHABILITATION	102,252	0	9,036	33,066	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,763,201	216,721	9,514	422,537	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,728,372	121,133	11,996	397,491	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,206,887	178,523	9,193	364,094	88.02
91.00	09100	EMERGENCY	1,521,416	121,115	45,675	401,830	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,232,247	2,394,596	1,523,977	7,258,420	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	760,294	74,580	31,734	213,517	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	194.00
194.01	07951	AUXILIARY	38,968	12,801	0	12,782	194.01
194.02	07952	FOUNDATION	167,600	4,446	1,760	30,915	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	50,199,109	2,486,423	1,557,471	7,515,634	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,583,191					5.00
7.00	00700	OPERATION OF PLANT	337,215	1,766,412				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	35,056	2,872	186,505			8.00
9.00	00900	HOUSEKEEPING	201,061	7,181	0	1,060,386		9.00
10.00	01000	DIETARY	244,533	35,163	0	0	1,316,085	10.00
11.00	01100	CAFETERIA	0	0	0	0	365,041	11.00
13.00	01300	NURSING ADMINISTRATION	54,700	7,982	0	15,162	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	138,392	77,508	0	0	0	14.00
15.00	01500	PHARMACY	213,834	12,638	0	13,267	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	227,225	9,962	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,003,858	142,226	52,476	285,707	541,357	30.00
40.00	04000	SUBPROVIDER - IPF	1,012,271	218,751	19,892	150,671	327,297	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	324,085	105,475	15,078	58,279	0	50.00
53.00	05300	ANESTHESIOLOGY	10,913	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	280,963	32,866	12,969	0	0	54.00
54.01	05401	ULTRASOUND	82,776	7,544	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	41,095	4,656	0	0	0	54.02
56.00	05600	RADIOISOTOPE	86,926	28,240	0	0	0	56.00
57.00	05700	CT SCAN	111,555	7,952	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	145,637	228,337	0	0	0	58.00
60.00	06000	LABORATORY	785,453	43,448	0	29,376	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	220,411	20,031	6,087	22,743	0	65.00
66.00	06600	PHYSICAL THERAPY	214,945	50,538	5,649	22,743	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	70,835	2,903	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	17,812	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	59,998	24,853	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	193,182	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	138,984	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	449,109	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	245,890	83,222	18,300	81,021	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	35,887	16,886	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	34,060	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	569,098	176,860	20,130	65,386	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	533,002	98,854	16,590	69,650	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	650,906	145,688	6,365	34,588	0	88.02
91.00	09100	EMERGENCY	493,138	98,839	12,969	211,793	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,264,805	1,691,475	186,505	1,060,386	1,233,695	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	254,852	60,863	0	0	82,390	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	15,231	10,446	0	0	0	194.01
194.02	07952	FOUNDATION	48,303	3,628	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,583,191	1,766,412	186,505	1,060,386	1,316,085	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	365,041					11.00
13.00	01300	NURSING ADMINISTRATION	2,927	312,604				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,602	0	816,040			14.00
15.00	01500	PHARMACY	7,873	0	2,072	1,155,963		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,319	0	1,217	0	1,220,755	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	61,715	81,898	159,611	0	66,520	30.00
40.00	04000	SUBPROVIDER - IPF	76,481	101,493	31,006	0	80,923	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,686	35,413	352,235	0	58,802	50.00
53.00	05300	ANESTHESIOLOGY	0	0	10,035	0	19,057	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,970	0	4,476	0	43,881	54.00
54.01	05401	ULTRASOUND	7,174	0	4,219	0	47,528	54.01
54.02	03440	MAMMOGRAPHY	1,619	0	348	0	4,969	54.02
56.00	05600	RADIOISOTOPE	4,016	0	2,112	0	25,577	56.00
57.00	05700	CT SCAN	5,174	0	4,024	0	176,108	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,456	0	0	0	37,528	58.00
60.00	06000	LABORATORY	30,447	0	36,740	0	183,256	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	13,799	0	6,739	0	30,119	65.00
66.00	06600	PHYSICAL THERAPY	12,123	0	2,297	0	27,501	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,634	0	169	0	10,929	67.00
68.00	06800	SPEECH PATHOLOGY	577	0	0	0	1,657	68.00
69.00	06900	ELECTROCARDIOLOGY	2,338	0	3,129	0	17,664	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	21,919	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	7,158	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	966,852	104,150	73.00
75.00	07500	ASC (NON-DISTINCT PART)	21,543	28,588	44,977	0	45,540	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	1,592	2,113	5,004	0	3,336	76.00
76.97	07697	CARDIAC REHABILITATION	1,842	2,444	2,317	0	4,906	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	28,559	20,925	36,235	23,909	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	13,258	52,848	26,201	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	15,851	92,363	30,335	88.02
91.00	09100	EMERGENCY	24,186	32,096	88,707	0	121,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	356,093	312,604	811,468	1,148,298	1,220,755	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,647	0	3,304	7,665	0	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	1,451	0	188	0	0	194.01
194.02	07952	FOUNDATION	2,850	0	1,080	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	365,041	312,604	816,040	1,155,963	1,220,755	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	6,649,960	-645,028	6,004,932	30.00
40.00	04000	SUBPROVIDER - IPF	0	6,309,084	0	6,309,084	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,349,601	0	2,349,601	50.00
53.00	05300	ANESTHESIOLOGY	0	86,256	0	86,256	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,581,915	0	1,581,915	54.00
54.01	05401	ULTRASOUND	0	500,067	0	500,067	54.01
54.02	03440	MAMMOGRAPHY	0	226,857	0	226,857	54.02
56.00	05600	RADIOISOTOPE	0	515,285	0	515,285	56.00
57.00	05700	CT SCAN	0	777,609	0	777,609	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,030,204	0	1,030,204	58.00
60.00	06000	LABORATORY	0	4,437,658	0	4,437,658	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	645,028	645,028	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,254,085	0	1,254,085	65.00
66.00	06600	PHYSICAL THERAPY	0	1,246,786	0	1,246,786	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	388,684	0	388,684	67.00
68.00	06800	SPEECH PATHOLOGY	0	95,539	0	95,539	68.00
69.00	06900	ELECTROCARDIOLOGY	0	362,269	0	362,269	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,033,854	0	1,033,854	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	735,190	0	735,190	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,423,542	0	3,423,542	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	1,611,220	0	1,611,220	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	216,917	0	216,917	76.00
76.97	07697	CARDIAC REHABILITATION	0	189,923	0	189,923	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,353,075	0	3,353,075	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,069,395	0	3,069,395	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	3,734,793	0	3,734,793	88.02
91.00	09100	EMERGENCY	0	3,173,046	0	3,173,046	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	48,352,814	0	48,352,814	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,493,846	0	1,493,846	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	194.00
194.01	07951	AUXILIARY	0	91,867	0	91,867	194.01
194.02	07952	FOUNDATION	0	260,582	0	260,582	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	50,199,109	0	50,199,109	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
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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	29,991	2,684	32,675	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,957	243,266	272,813	521,036	5.00
7.00	00700	OPERATION OF PLANT	8,580	48,646	13,457	70,683	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,520	6,444	9,964	8.00
9.00	00900	HOUSEKEEPING	0	8,799	1,175	9,974	9.00
10.00	01000	DIETARY	0	43,088	7,227	50,315	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,781	68	9,849	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,944	94,976	20,131	118,051	14.00
15.00	01500	PHARMACY	0	15,487	116,680	132,167	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,208	1,620	13,828	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,055	174,280	96,126	272,461	30.00
40.00	04000	SUBPROVIDER - IPF	0	268,052	13,369	281,421	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	140,152	129,247	186,189	455,588	50.00
53.00	05300	ANESTHESIOLOGY	10,479	0	12,365	22,844	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	40,273	120,690	160,963	54.00
54.01	05401	ULTRASOUND	0	9,244	67,554	76,798	54.01
54.02	03440	MAMMOGRAPHY	0	5,706	7,330	13,036	54.02
56.00	05600	RADIOISOTOPE	0	34,604	1,948	36,552	56.00
57.00	05700	CT SCAN	0	9,744	48,096	57,840	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	279,796	210,604	490,400	58.00
60.00	06000	LABORATORY	0	53,240	136,026	189,266	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	30,308	24,545	16,035	70,888	65.00
66.00	06600	PHYSICAL THERAPY	0	61,928	7,912	69,840	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,557	0	3,557	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	35,365	30,455	8,052	73,872	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	0	101,979	53,417	155,396	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	20,692	10,551	31,243	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	9,036	9,036	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,757	216,721	9,514	227,992	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	121,133	11,996	133,129	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,400	178,523	9,193	193,116	88.02
91.00	09100	EMERGENCY	0	121,115	45,675	166,790	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	241,997	2,394,596	1,523,977	4,160,570	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,027	74,580	31,734	115,341	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	194.00
194.01	07951	AUXILIARY	0	12,801	0	12,801	194.01
194.02	07952	FOUNDATION	0	4,446	1,760	6,206	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	251,024	2,486,423	1,557,471	4,294,918	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	526,105					5.00
7.00	00700	OPERATION OF PLANT	18,512	89,842				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,925	146	12,105			8.00
9.00	00900	HOUSEKEEPING	11,038	365	0	22,195		9.00
10.00	01000	DIETARY	13,424	1,788	0	0	66,413	10.00
11.00	01100	CAFETERIA	0	0	0	0	18,421	11.00
13.00	01300	NURSING ADMINISTRATION	3,003	406	0	317	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,597	3,942	0	0	0	14.00
15.00	01500	PHARMACY	11,739	643	0	278	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,474	507	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	55,110	7,234	3,404	5,979	27,318	30.00
40.00	04000	SUBPROVIDER - IPF	55,580	11,126	1,291	3,154	16,516	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	17,792	5,365	979	1,220	0	50.00
53.00	05300	ANESTHESIOLOGY	599	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,424	1,672	842	0	0	54.00
54.01	05401	ULTRASOUND	4,544	384	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	2,256	237	0	0	0	54.02
56.00	05600	RADIOISOTOPE	4,772	1,436	0	0	0	56.00
57.00	05700	CT SCAN	6,124	404	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,995	11,612	0	0	0	58.00
60.00	06000	LABORATORY	43,120	2,210	0	615	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	12,100	1,019	395	476	0	65.00
66.00	06600	PHYSICAL THERAPY	11,800	2,570	367	476	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,889	148	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	978	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,294	1,264	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,605	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,630	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,655	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	13,499	4,233	1,188	1,696	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	1,970	859	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,870	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	31,242	8,995	1,307	1,369	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	29,261	5,028	1,077	1,458	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	35,733	7,410	413	724	0	88.02
91.00	09100	EMERGENCY	27,072	5,027	842	4,433	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	508,626	86,030	12,105	22,195	62,255	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,991	3,096	0	0	4,158	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	836	531	0	0	0	194.01
194.02	07952	FOUNDATION	2,652	185	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	526,105	89,842	12,105	22,195	66,413	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 2:19 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	18,421					11.00
13.00	01300	NURSING ADMINISTRATION	148	13,814				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	686	0	130,670			14.00
15.00	01500	PHARMACY	397	0	332	146,353		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	975	0	195	0	28,820	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,114	3,619	25,558	0	1,568	30.00
40.00	04000	SUBPROVIDER - IPF	3,860	4,486	4,965	0	1,908	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,347	1,565	56,402	0	1,386	50.00
53.00	05300	ANESTHESIOLOGY	0	0	1,607	0	449	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	806	0	717	0	1,035	54.00
54.01	05401	ULTRASOUND	362	0	676	0	1,120	54.01
54.02	03440	MAMMOGRAPHY	82	0	56	0	117	54.02
56.00	05600	RADIOISOTOPE	203	0	338	0	603	56.00
57.00	05700	CT SCAN	261	0	644	0	4,152	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	73	0	0	0	885	58.00
60.00	06000	LABORATORY	1,536	0	5,883	0	4,360	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	696	0	1,079	0	710	65.00
66.00	06600	PHYSICAL THERAPY	612	0	368	0	648	66.00
67.00	06700	OCCUPATIONAL THERAPY	183	0	27	0	258	67.00
68.00	06800	SPEECH PATHOLOGY	29	0	0	0	39	68.00
69.00	06900	ELECTROCARDIOLOGY	118	0	501	0	416	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	517	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	169	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	122,410	2,455	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,087	1,263	7,202	0	1,074	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	80	93	801	0	79	76.00
76.97	07697	CARDIAC REHABILITATION	93	108	371	0	116	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,262	3,351	4,588	564	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	2,123	6,691	618	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	2,538	11,694	715	88.02
91.00	09100	EMERGENCY	1,221	1,418	14,204	0	2,859	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,969	13,814	129,938	145,383	28,820	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	235	0	529	970	0	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	73	0	30	0	0	194.01
194.02	07952	FOUNDATION	144	0	173	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,421	13,814	130,670	146,353	28,820	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 2:19 pm

Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		408,970	0	408,970	30.00
40.00	04000	SUBPROVIDER - IPF		388,130	0	388,130	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		542,510	0	542,510	50.00
53.00	05300	ANESTHESIOLOGY		25,499	0	25,499	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		182,369	0	182,369	54.00
54.01	05401	ULTRASOUND		84,152	0	84,152	54.01
54.02	03440	MAMMOGRAPHY		15,889	0	15,889	54.02
56.00	05600	RADIOISOTOPE		44,015	0	44,015	56.00
57.00	05700	CT SCAN		69,727	0	69,727	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		511,072	0	511,072	58.00
60.00	06000	LABORATORY		248,451	0	248,451	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		88,230	0	88,230	65.00
66.00	06600	PHYSICAL THERAPY		87,580	0	87,580	66.00
67.00	06700	OCCUPATIONAL THERAPY		8,378	0	8,378	67.00
68.00	06800	SPEECH PATHOLOGY		1,128	0	1,128	68.00
69.00	06900	ELECTROCARDIOLOGY		79,655	0	79,655	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		11,122	0	11,122	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		7,799	0	7,799	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		149,520	0	149,520	73.00
75.00	07500	ASC (NON-DISTINCT PART)		187,505	0	187,505	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY		35,251	0	35,251	76.00
76.97	07697	CARDIAC REHABILITATION		11,738	0	11,738	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		282,507	0	282,507	88.00
88.01	08801	RURAL HEALTH CLINIC II		181,113	0	181,113	88.01
88.02	08802	RURAL HEALTH CLINIC III		253,926	0	253,926	88.02
91.00	09100	EMERGENCY		225,613	0	225,613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,131,849	0	4,131,849	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES		139,248	0	139,248	192.00
194.00	07950	RETAIL 340B PHARMACY		0	0	0	194.00
194.01	07951	AUXILIARY		14,327	0	14,327	194.01
194.02	07952	FOUNDATION		9,494	0	9,494	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,294,918	0	4,294,918	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0210

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

Worksheet B-1

Date/Time Prepared:
11/29/2021 2:19 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	134,222					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,513,622				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,619	2,608	22,550,427			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,132	265,132	3,498,499	-9,583,191	40,615,918	5.00
7.00	00700	OPERATION OF PLANT	2,626	13,078	446,272	0	1,429,197	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	190	6,263	48,173	0	148,577	8.00
9.00	00900	HOUSEKEEPING	475	1,142	564,347	0	852,144	9.00
10.00	01000	DIETARY	2,326	7,024	611,750	0	1,036,389	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	528	66	62,773	0	231,833	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,127	19,564	271,898	0	586,538	14.00
15.00	01500	PHARMACY	836	113,395	550,151	0	906,279	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	659	1,574	580,652	0	963,032	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,408	93,420	2,487,927	0	4,254,592	30.00
40.00	04000	SUBPROVIDER - IPF	14,470	12,993	2,638,330	0	4,290,299	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,977	180,947	597,991	0	1,373,548	50.00
53.00	05300	ANESTHESIOLOGY	0	12,017	0	0	46,251	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,174	117,292	627,766	0	1,190,790	54.00
54.01	05401	ULTRASOUND	499	65,652	185,037	0	350,826	54.01
54.02	03440	MAMMOGRAPHY	308	7,124	72,653	0	174,170	54.02
56.00	05600	RADIOISOTOPE	1,868	1,893	76,521	0	368,414	56.00
57.00	05700	CT SCAN	526	46,742	208,423	0	472,796	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,104	204,675	74,058	0	617,246	58.00
60.00	06000	LABORATORY	2,874	132,196	1,008,477	0	3,328,938	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,325	15,584	598,144	0	934,156	65.00
66.00	06600	PHYSICAL THERAPY	3,343	7,689	620,152	0	910,990	66.00
67.00	06700	OCCUPATIONAL THERAPY	192	0	217,760	0	300,214	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	56,309	0	75,493	68.00
69.00	06900	ELECTROCARDIOLOGY	1,644	7,825	131,145	0	254,287	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	818,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	589,048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,903,431	73.00
75.00	07500	ASC (NON-DISTINCT PART)	5,505	51,913	598,362	0	1,042,139	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	1,117	10,254	87,276	0	152,099	76.00
76.97	07697	CARDIAC REHABILITATION	0	8,782	99,214	0	144,354	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	11,699	9,246	1,267,811	0	2,411,973	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,539	11,658	1,192,659	0	2,258,992	88.01
88.02	08802	RURAL HEALTH CLINIC III	9,637	8,934	1,092,455	0	2,758,697	88.02
91.00	09100	EMERGENCY	6,538	44,389	1,205,679	0	2,090,036	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	129,265	1,481,071	21,778,664	-9,583,191	39,266,521	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,026	30,841	640,651	0	1,080,125	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	691	0	38,353	0	64,551	194.01
194.02	07952	FOUNDATION	240	1,710	92,759	0	204,721	194.02
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)	2,486,423	1,557,471	7,515,634		9,583,191	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.524705	1.028970	0.333281		0.235947	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			32,675		526,105	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001449		0.012953	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: 14-0210

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

Worksheet B-1

Date/Time Prepared:
11/29/2021 2:19 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (MEALS SERVED)	CAFETERIA (ASSIGNED TIME)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	116,845				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	190	46,880			8.00
9.00	00900	HOUSEKEEPING	475	0	2,238		9.00
10.00	01000	DIETARY	2,326	0	0	150,601	10.00
11.00	01100	CAFETERIA	0	0	0	41,772	11.00
13.00	01300	NURSING ADMINISTRATION	528	0	32	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,127	0	0	0	14.00
15.00	01500	PHARMACY	836	0	28	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	659	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,408	13,190	603	61,948	30.00
40.00	04000	SUBPROVIDER - IPF	14,470	5,000	318	37,453	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,977	3,790	123	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,174	3,260	0	0	54.00
54.01	05401	ULTRASOUND	499	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	308	0	0	0	54.02
56.00	05600	RADIOISOTOPE	1,868	0	0	0	56.00
57.00	05700	CT SCAN	526	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,104	0	0	0	58.00
60.00	06000	LABORATORY	2,874	0	62	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,325	1,530	48	0	65.00
66.00	06600	PHYSICAL THERAPY	3,343	1,420	48	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	192	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,644	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	5,505	4,600	171	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	1,117	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	11,699	5,060	138	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,539	4,170	147	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	9,637	1,600	73	0	88.02
91.00	09100	EMERGENCY	6,538	3,260	447	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	111,888	46,880	2,238	141,173	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,026	0	0	9,428	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	194.00
194.01	07951	AUXILIARY	691	0	0	0	194.01
194.02	07952	FOUNDATION	240	0	0	0	194.02
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)	1,766,412	186,505	1,060,386	1,316,085	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.117566	3.978349	473.809651	8.738886	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	89,842	12,105	22,195	66,413	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.768899	0.258212	9.917337	0.440986	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: 14-0210

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

Worksheet B-1

Date/Time Prepared:
11/29/2021 2:19 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	355,333					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	686,836				14.00
15.00	01500	PHARMACY	0	1,744	2,275,733			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,024	0	122,462,365		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	93,092	134,340	0	6,673,317	0	30.00
40.00	04000	SUBPROVIDER - IPF	115,365	26,097	0	8,118,286	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	40,254	296,465	0	5,899,029	0	50.00
53.00	05300	ANESTHESIOLOGY	0	8,446	0	1,911,857	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,767	0	4,402,192	0	54.00
54.01	05401	ULTRASOUND	0	3,551	0	4,768,017	0	54.01
54.02	03440	MAMMOGRAPHY	0	293	0	498,489	0	54.02
56.00	05600	RADIOISOTOPE	0	1,778	0	2,565,909	0	56.00
57.00	05700	CT SCAN	0	3,387	0	17,667,336	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,764,860	0	58.00
60.00	06000	LABORATORY	0	30,923	0	18,379,364	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,672	0	3,021,557	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,933	0	2,758,975	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	142	0	1,096,365	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	166,275	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,634	0	1,772,072	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,198,888	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	718,064	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,903,431	10,448,478	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	32,496	37,856	0	4,568,660	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	2,402	4,212	0	334,674	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,778	1,950	0	492,204	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	32,463	17,612	71,336	2,398,601	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	11,159	104,042	2,628,469	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	13,341	181,834	3,043,266	0	88.02
91.00	09100	EMERGENCY	36,483	74,662	0	12,167,161	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	355,333	682,988	2,260,643	122,462,365	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,781	15,090	0	0	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	0	158	0	0	0	194.01
194.02	07952	FOUNDATION	0	909	0	0	0	194.02
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)	312,604	816,040	1,155,963	1,220,755	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.879749	1.188115	0.507952	0.009968	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	13,814	130,670	146,353	28,820	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.038876	0.190249	0.064310	0.000235	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Provider CCN: 14-0210

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

Worksheet B-2

Date/Time Prepared:
11/29/2021 2:19 pm

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0 1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0 2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0 3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0 4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0 5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0 6.00
7.00		ADULTS & PEDIATRICS		1	30.00	-645,028 7.00
8.00		IV THERAPY		1	64.00	645,028 8.00

Worksheet C
Part I
Date/Time Prepared:
11/29/2021 2:19 pm

MCRIF32 - 16.12.172.5

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 2:19 pm

			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,432,932		2,432,932			30.00
40.00	04000	SUBPROVIDER - IPF	8,118,286		8,118,286			40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	411,391	5,487,638	5,899,029	0.398303	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	87,355	1,824,502	1,911,857	0.045116	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	180,670	4,221,522	4,402,192	0.359347	0.000000	54.00
54.01	05401	ULTRASOUND	360,630	4,407,387	4,768,017	0.104879	0.000000	54.01
54.02	03440	MAMMOGRAPHY	332	498,157	498,489	0.455089	0.000000	54.02
56.00	05600	RADIOISOTOPE	75,779	2,490,130	2,565,909	0.200820	0.000000	56.00
57.00	05700	CT SCAN	1,329,395	16,337,941	17,667,336	0.044014	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	75,240	3,689,620	3,764,860	0.273637	0.000000	58.00
60.00	06000	LABORATORY	1,831,787	16,547,577	18,379,364	0.241448	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	201,270	878,537	1,079,807	0.597355	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,669,146	1,352,411	3,021,557	0.415046	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	488,553	2,270,422	2,758,975	0.451902	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	363,613	732,752	1,096,365	0.354521	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	9,134	157,141	166,275	0.574584	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	164,946	1,607,126	1,772,072	0.204432	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	517,001	1,681,887	2,198,888	0.470171	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	78,245	639,819	718,064	1.023850	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,285,665	8,162,813	10,448,478	0.327659	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	77,500	4,491,160	4,568,660	0.352668	0.000000	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	390	334,284	334,674	0.648144	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	795	491,409	492,204	0.385862	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	2,398,601	2,398,601			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,628,469	2,628,469			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	3,043,266	3,043,266			88.02
91.00	09100	EMERGENCY	918,820	11,248,341	12,167,161	0.260788	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	501,314	2,659,264	3,160,578	0.764261	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,180,189	100,282,176	122,462,365			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,180,189	100,282,176	122,462,365			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0210	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/29/2021 2:19 pm
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - IPF			40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.398303		50.00
53.00	05300	ANESTHESIOLOGY	0.045116		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.359347		54.00
54.01	05401	ULTRASOUND	0.104879		54.01
54.02	03440	MAMMOGRAPHY	0.455089		54.02
56.00	05600	RADIOISOTOPE	0.200820		56.00
57.00	05700	CT SCAN	0.044014		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.273637		58.00
60.00	06000	LABORATORY	0.241573		60.00
64.00	06400	INTRAVENOUS THERAPY	0.597355		64.00
65.00	06500	RESPIRATORY THERAPY	0.415046		65.00
66.00	06600	PHYSICAL THERAPY	0.451902		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.354521		67.00
68.00	06800	SPEECH PATHOLOGY	0.574584		68.00
69.00	06900	ELECTROCARDIOLOGY	0.204432		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470171		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.023850		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.327659		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.352668		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.648144		76.00
76.97	07697	CARDIAC REHABILITATION	0.385862		76.97
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	0.260788		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.764261		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/29/2021 2:19 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS 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		408,970	173	408,797	3,136	130.36	30.00
40.00	SUBPROVIDER - IPF		388,130	0	388,130	6,052	64.13	40.00
200.00	Total (lines 30 through 199)		797,100		796,927	9,188		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		1,195	155,780				
40.00	SUBPROVIDER - IPF		1,855	118,961				
200.00	Total (lines 30 through 199)		3,050	274,741				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/29/2021 2:19 pm

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	542,510	5,899,029	0.091966	261,380	24,038	50.00
53.00	05300	ANESTHESIOLOGY	25,499	1,911,857	0.013337	50	1	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	182,369	4,402,192	0.041427	161,546	6,692	54.00
54.01	05401	ULTRASOUND	84,152	4,768,017	0.017649	309,405	5,461	54.01
54.02	03440	MAMMOGRAPHY	15,889	498,489	0.031874	0	0	54.02
56.00	05600	RADIOISOTOPE	44,015	2,565,909	0.017154	30,832	529	56.00
57.00	05700	CT SCAN	69,727	17,667,336	0.003947	1,203,979	4,752	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	511,072	3,764,860	0.135748	71,169	9,661	58.00
60.00	06000	LABORATORY	248,451	18,379,364	0.013518	1,505,121	20,346	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,079,807	0.000000	117,792	0	64.00
65.00	06500	RESPIRATORY THERAPY	88,230	3,021,557	0.029200	1,056,512	30,850	65.00
66.00	06600	PHYSICAL THERAPY	87,580	2,758,975	0.031744	213,316	6,772	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,378	1,096,365	0.007642	168,836	1,290	67.00
68.00	06800	SPEECH PATHOLOGY	1,128	166,275	0.006784	6,233	42	68.00
69.00	06900	ELECTROCARDIOLOGY	79,655	1,772,072	0.044950	138,493	6,225	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,122	2,198,888	0.005058	337,666	1,708	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,799	718,064	0.010861	52,439	570	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	149,520	10,448,478	0.014310	1,057,235	15,129	73.00
75.00	07500	ASC (NON-DISTINCT PART)	187,505	4,568,660	0.041042	23,383	960	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	35,251	334,674	0.105329	326	34	76.00
76.97	07697	CARDIAC REHABILITATION	11,738	492,204	0.023848	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	282,507	2,398,601	0.117780	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	181,113	2,628,469	0.068904	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	253,926	3,043,266	0.083439	0	0	88.02
91.00	09100	EMERGENCY	225,613	12,167,161	0.018543	806,196	14,949	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	164,510	3,160,578	0.052051	256,660	13,359	92.00
200.00		Total (lines 50 through 199)	3,499,259	111,911,147		7,778,569	163,368	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0210		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/29/2021 2:19 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	3,136	0.00	1,195			30.00	
40.00	04000	SUBPROVIDER - IPF	0	0	6,052	0.00	1,855			40.00	
200.00		Total (lines 30 through 199)		0	9,188		3,050			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
40.00	04000	SUBPROVIDER - IPF	0								40.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0210		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 2:19 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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
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: 14-0210		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 2:19 pm	
			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	5,899,029	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,911,857	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,402,192	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	4,768,017	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	498,489	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	2,565,909	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	17,667,336	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,764,860	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	18,379,364	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,079,807	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,021,557	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,758,975	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,096,365	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	166,275	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,772,072	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,198,888	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	718,064	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,448,478	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	4,568,660	0.000000	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	334,674	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	492,204	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,398,601	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,628,469	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	3,043,266	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	12,167,161	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,160,578	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	111,911,147		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 2:19 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	261,380	0	3,276,065	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	50	0	1,725	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	161,546	0	1,268,426	0	54.00
54.01	05401	ULTRASOUND	0.000000	309,405	0	1,844,805	0	54.01
54.02	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.000000	30,832	0	1,169,635	0	56.00
57.00	05700	CT SCAN	0.000000	1,203,979	0	5,739,510	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	71,169	0	1,210,701	0	58.00
60.00	06000	LABORATORY	0.000000	1,505,121	0	2,352,622	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	117,792	0	355,700	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,056,512	0	439,009	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	213,316	0	37,449	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	168,836	0	24,215	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	6,233	0	175	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	138,493	0	637,059	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	337,666	0	484,896	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	52,439	0	212,069	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,057,235	0	4,213,382	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	23,383	0	637,809	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.000000	326	0	176,536	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	225,515	0	76.97
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	806,196	0	2,990,374	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	256,660	0	966,976	0	92.00
200.00		Total (lines 50 through 199)		7,778,569	0	28,264,653	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0210		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/29/2021 2:19 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.398303	3,276,065	0	0	1,304,867	50.00
53.00	05300	ANESTHESIOLOGY	0.045116	1,725	0	0	78	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.359347	1,268,426	0	0	455,805	54.00
54.01	05401	ULTRASOUND	0.104879	1,844,805	0	0	193,481	54.01
54.02	03440	MAMMOGRAPHY	0.455089	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.200820	1,169,635	0	0	234,886	56.00
57.00	05700	CT SCAN	0.044014	5,739,510	0	0	252,619	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.273637	1,210,701	0	0	331,293	58.00
60.00	06000	LABORATORY	0.241448	2,352,622	0	0	568,036	60.00
64.00	06400	INTRAVENOUS THERAPY	0.597355	355,700	0	0	212,479	64.00
65.00	06500	RESPIRATORY THERAPY	0.415046	439,009	0	0	182,209	65.00
66.00	06600	PHYSICAL THERAPY	0.451902	37,449	0	0	16,923	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.354521	24,215	0	0	8,585	67.00
68.00	06800	SPEECH PATHOLOGY	0.574584	175	0	0	101	68.00
69.00	06900	ELECTROCARDIOLOGY	0.204432	637,059	0	0	130,235	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470171	484,896	0	0	227,984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.023850	212,069	0	0	217,127	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.327659	4,213,382	0	4,852	1,380,553	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.352668	637,809	0	111	224,935	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.648144	176,536	0	0	114,421	76.00
76.97	07697	CARDIAC REHABILITATION	0.385862	225,515	0	0	87,018	76.97
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	0.260788	2,990,374	0	99	779,854	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.764261	966,976	0	0	739,022	92.00
200.00		Subtotal (see instructions)		28,264,653	0	5,062	7,662,511	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		28,264,653	0	5,062	7,662,511	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0210		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Prepared: 11/29/2021 2:19 pm
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
54.02	03440	MAMMOGRAPHY	0	0		54.02
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,590		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	39		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
91.00	09100	EMERGENCY	0	26		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	1,655		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,655		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0210 Component CCN: 14-S210		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part II Date/Time Prepared: 11/29/2021 2:19 pm	
				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	542,510	5,899,029	0.091966	25,588	2,353	50.00	
53.00	05300	ANESTHESIOLOGY	25,499	1,911,857	0.013337	7	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	182,369	4,402,192	0.041427	18,272	757	54.00	
54.01	05401	ULTRASOUND	84,152	4,768,017	0.017649	10,553	186	54.01	
54.02	03440	MAMMOGRAPHY	15,889	498,489	0.031874	0	0	54.02	
56.00	05600	RADIOISOTOPE	44,015	2,565,909	0.017154	6,452	111	56.00	
57.00	05700	CT SCAN	69,727	17,667,336	0.003947	125,416	495	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	511,072	3,764,860	0.135748	0	0	58.00	
60.00	06000	LABORATORY	248,451	18,379,364	0.013518	248,192	3,355	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	1,079,807	0.000000	12,073	0	64.00	
65.00	06500	RESPIRATORY THERAPY	88,230	3,021,557	0.029200	174,551	5,097	65.00	
66.00	06600	PHYSICAL THERAPY	87,580	2,758,975	0.031744	58,506	1,857	66.00	
67.00	06700	OCCUPATIONAL THERAPY	8,378	1,096,365	0.007642	21,282	163	67.00	
68.00	06800	SPEECH PATHOLOGY	1,128	166,275	0.006784	444	3	68.00	
69.00	06900	ELECTROCARDIOLOGY	79,655	1,772,072	0.044950	23,285	1,047	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,122	2,198,888	0.005058	19,796	100	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,799	718,064	0.010861	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	149,520	10,448,478	0.014310	308,868	4,420	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	187,505	4,568,660	0.041042	11,794	484	75.00	
76.00	03950	FAITH CENTER CHEMOTHERAPY	35,251	334,674	0.105329	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	11,738	492,204	0.023848	0	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	282,507	2,398,601	0.117780	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	181,113	2,628,469	0.068904	0	0	88.01	
88.02	08802	RURAL HEALTH CLINIC III	253,926	3,043,266	0.083439	0	0	88.02	
91.00	09100	EMERGENCY	225,613	12,167,161	0.018543	112,624	2,088	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,160,578	0.000000	0	0	92.00	
200.00		Total (lines 50 through 199)	3,334,749	111,911,147		1,177,703	22,516	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0210 Component CCN: 14-S210		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 2:19 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	ULTRASOUND		0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY		0	0	0	0	0	54.02
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	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
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
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		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
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY		0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
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
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: 14-0210 Component CCN: 14-S210		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 2:19 pm	
			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	5,899,029	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,911,857	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,402,192	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	4,768,017	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	498,489	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	2,565,909	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	17,667,336	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,764,860	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	18,379,364	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,079,807	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,021,557	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,758,975	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,096,365	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	166,275	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,772,072	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,198,888	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	718,064	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,448,478	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	4,568,660	0.000000	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	334,674	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	492,204	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,398,601	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,628,469	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	3,043,266	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	12,167,161	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,160,578	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	111,911,147		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0210 Component CCN: 14-S210		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 2:19 pm	
				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	25,588	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY		0.000000	7	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	18,272	0	759	0	54.00
54.01	05401	ULTRASOUND		0.000000	10,553	0	0	0	54.01
54.02	03440	MAMMOGRAPHY		0.000000	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE		0.000000	6,452	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	125,416	0	2,080	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY		0.000000	248,192	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	12,073	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	174,551	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	58,506	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	21,282	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	444	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	23,285	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	19,796	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	308,868	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)		0.000000	11,794	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY		0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
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	112,624	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			1,177,703	0	2,839	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0210 Component CCN: 14-S210		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/29/2021 2:19 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	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	0.398303	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.045116	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.359347	759	0	0	273	54.00
54.01	05401	ULTRASOUND	0.104879	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.455089	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.200820	0	0	0	0	56.00
57.00	05700	CT SCAN	0.044014	2,080	0	0	92	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.273637	0	0	0	0	58.00
60.00	06000	LABORATORY	0.241448	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.597355	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.415046	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.451902	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.354521	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.574584	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.204432	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470171	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.023850	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.327659	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.352668	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.648144	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.385862	0	0	0	0	76.97
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	0.260788	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.764261	0	0	0	0	92.00
200.00		Subtotal (see instructions)		2,839	0	0	365	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		2,839	0	0	365	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0210

Period:

Worksheet D

Component CCN: 14-S210

From 07/01/2020
To 06/30/2021Part V
Date/Time Prepared:
11/29/2021 2:19 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Costs			
			Cost	Cost		
			Reimbursed	Reimbursed		
			Services Subject To Ded. & Coins. (see inst.)	Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00	
54.01	05401	ULTRASOUND	0	0	54.01	
54.02	03440	MAMMOGRAPHY	0	0	54.02	
56.00	05600	RADIOISOTOPE	0	0	56.00	
57.00	05700	CT SCAN	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00	
60.00	06000	LABORATORY	0	0	60.00	
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	
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00	
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0	0	76.97	
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00	
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	
200.00		Subtotal (see instructions)	0	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00	
202.00		Net Charges (line 200 - line 201)	0	0	202.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0210	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 2:19 pm
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)			3,437 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,136 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,874 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			165 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)			121 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			5 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)			10 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			1,195 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)			160 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)			47 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			169.71 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			169.71 20.00
21.00	Total general inpatient routine service cost (see instructions)			6,004,932 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)			849 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)			1,697 25.00
26.00	Total swing-bed cost (see instructions)			2,546 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			6,002,386 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)			6,002,386 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)			1,914.03 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,287,266 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)			2,287,266 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0210

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

Worksheet D-1

Date/Time Prepared:
11/29/2021 2:19 pm

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)						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)					2,307,600	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,594,866	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)					155,780	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					163,368	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					319,148	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,275,718	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)					1,262	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,914.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,415,506	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0210

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

Worksheet D-1

Date/Time Prepared:
11/29/2021 2:19 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		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	408,970	6,004,932	0.068106	2,415,506	164,510
91.00	Nursing School cost	0	6,004,932	0.000000	2,415,506	0
92.00	Allied health cost	0	6,004,932	0.000000	2,415,506	0
93.00	All other Medical Education	0	6,004,932	0.000000	2,415,506	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 2:19 pm
		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)		6,052	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,052	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		6,052	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,855	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)		6,409,734	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)		6,409,734	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)		6,409,734	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)		1,059.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,964,649	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,964,649	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 2:19 pm
			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)					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)					347,336 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,311,985 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)					118,961 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					22,516 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					141,477 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,170,508 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)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0210 Component CCN: 14-S210		Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 2:19 pm	
			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	388,130	6,409,734	0.060553	0	0	90.00
91.00	Nursing School cost	0	6,409,734	0.000000	0	0	91.00
92.00	Allied health cost	0	6,409,734	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,409,734	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0210	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 2:19 pm
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,405,114	30.00
40.00	04000	SUBPROVIDER - IPF		21,648	40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.398303	261,380	50.00
53.00	05300	ANESTHESIOLOGY	0.045116	50	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.359347	161,546	54.00
54.01	05401	ULTRASOUND	0.104879	309,405	54.01
54.02	03440	MAMMOGRAPHY	0.455089	0	54.02
56.00	05600	RADIOISOTOPE	0.200820	30,832	56.00
57.00	05700	CT SCAN	0.044014	1,203,979	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.273637	71,169	58.00
60.00	06000	LABORATORY	0.241573	1,505,121	60.00
64.00	06400	INTRAVENOUS THERAPY	0.597355	117,792	64.00
65.00	06500	RESPIRATORY THERAPY	0.415046	1,056,512	65.00
66.00	06600	PHYSICAL THERAPY	0.451902	213,316	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.354521	168,836	67.00
68.00	06800	SPEECH PATHOLOGY	0.574584	6,233	68.00
69.00	06900	ELECTROCARDIOLOGY	0.204432	138,493	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470171	337,666	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.023850	52,439	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.327659	1,057,235	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.352668	23,383	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.648144	326	76.00
76.97	07697	CARDIAC REHABILITATION	0.385862	0	76.97
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	0.260788	806,196	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.764261	256,660	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,778,569	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)		7,778,569	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 2:19 pm	
		Title XVIII	Subprovider - IPF	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
40.00	04000 SUBPROVIDER - IPF		2,511,832		40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.398303	25,588	10,192	50.00
53.00	05300 ANESTHESIOLOGY	0.045116	7	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.359347	18,272	6,566	54.00
54.01	05401 ULTRASOUND	0.104879	10,553	1,107	54.01
54.02	03440 MAMMOGRAPHY	0.455089	0	0	54.02
56.00	05600 RADIOISOTOPE	0.200820	6,452	1,296	56.00
57.00	05700 CT SCAN	0.044014	125,416	5,520	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.273637	0	0	58.00
60.00	06000 LABORATORY	0.241573	248,192	59,956	60.00
64.00	06400 INTRAVENOUS THERAPY	0.597355	12,073	7,212	64.00
65.00	06500 RESPIRATORY THERAPY	0.415046	174,551	72,447	65.00
66.00	06600 PHYSICAL THERAPY	0.451902	58,506	26,439	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.354521	21,282	7,545	67.00
68.00	06800 SPEECH PATHOLOGY	0.574584	444	255	68.00
69.00	06900 ELECTROCARDIOLOGY	0.204432	23,285	4,760	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470171	19,796	9,308	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.023850	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.327659	308,868	101,203	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.352668	11,794	4,159	75.00
76.00	03950 FAITH CENTER CHEMOTHERAPY	0.648144	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.385862	0	0	76.97
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	0.260788	112,624	29,371	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.764261	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,177,703	347,336	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,177,703		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0210 Component CCN: 14-U210	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 2:19 pm	
Cost Center Description			Title XVIII	Swing Beds - SNF	PPS	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
40.00	04000	SUBPROVIDER - IPF				40.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.398303	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.045116	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.359347	852	306	54.00
54.01	05401	ULTRASOUND	0.104879	597	63	54.01
54.02	03440	MAMMOGRAPHY	0.455089	0	0	54.02
56.00	05600	RADIOISOTOPE	0.200820	0	0	56.00
57.00	05700	CT SCAN	0.044014	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.273637	0	0	58.00
60.00	06000	LABORATORY	0.241573	31,056	7,502	60.00
64.00	06400	INTRAVENOUS THERAPY	0.597355	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.415046	71,252	29,573	65.00
66.00	06600	PHYSICAL THERAPY	0.451902	73,728	33,318	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.354521	63,147	22,387	67.00
68.00	06800	SPEECH PATHOLOGY	0.574584	652	375	68.00
69.00	06900	ELECTROCARDIOLOGY	0.204432	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470171	26,121	12,281	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.023850	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.327659	142,110	46,564	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.352668	222	78	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.648144	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.385862	0	0	76.97
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	0.260788	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.764261	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		409,737	152,447	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)		409,737		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0210	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/29/2021 2:19 pm
		Title XVIII	Hospital	PPS
			1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	768,877		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,336,876		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		33.72	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)		6.13	30.00
31.00	Percentage of Medicaid patient days (see instructions)		14.99	31.00
32.00	Sum of lines 30 and 31		21.12	32.00
33.00	Allowable disproportionate share percentage (see instructions)		6.64	33.00
34.00	Disproportionate share adjustment (see instructions)		51,555	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0210	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/29/2021 2:19 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	8,350,599,096	8,290,014,521	35.00
35.01	Factor 3 (see instructions)	0.000142815	0.000100475	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,192,594	832,939	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	299,778	622,993	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	922,771		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	4,080,079		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	3,945,267		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		4,080,079	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		234,253	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		21,987	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)		4,336,319	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		4,336,319	61.00
62.00	Deductibles billed to program beneficiaries		437,876	62.00
63.00	Coinsurance billed to program beneficiaries		371	63.00
64.00	Allowable bad debts (see instructions)		224,978	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		146,236	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		180,147	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		4,044,308	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)		1,933	70.93
70.94	HRR adjustment amount (see instructions)		-5,039	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0210	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/29/2021 2:19 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2020	172,939	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2021	545,122	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		37,468	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,721,795	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		4,697,187	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)		24,608	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	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2021 2:19 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	768,877	0	768,877		768,877
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,336,876	0		2,336,876	2,336,876
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0664	0.0664	0.0664	0.0664	
11.00	Disproportionate share adjustment (see instructions)	34.00	51,555	0	12,763	38,792	51,555
11.01	Uncompensated care payments	36.00	922,771	0	299,778	622,993	922,771
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	4,080,079	0	1,081,418	2,998,661	4,080,079
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,080,079	0	1,081,418	2,998,661	4,080,079
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	234,253	0	61,116	173,137	234,253
17.00	Special add-on payments for new technologies	54.00	21,987	0	0	21,987	21,987
17.01	Net organ acquisition cost						

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2021 2:19 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	1,142,534	3,193,785	4,336,319
		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	234,253	0	61,116	173,137	234,253
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	234,253	0	61,116	173,137	234,253
		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				0.151364	0.170682	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			172,939		172,939
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				545,122	545,122
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/29/2021 2:19 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	768,877	768,877		768,877	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,336,876		2,336,876	2,336,876	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0664	0.0664	0.0664		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	51,555	12,763	38,792	51,555	11.00
11.01	Uncompensated care payments	36.00	922,771	299,778	622,993	922,771	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	4,080,079	1,081,418	2,998,661	4,080,079	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,080,079	1,081,418	2,998,661	4,080,079	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	234,253	61,116	173,137	234,253	16.00
17.00	Special add-on payments for new technologies	54.00	21,987	0	21,987	21,987	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			1,142,534	3,193,785	4,336,319	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/29/2021 2:19 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	234,253	61,116	173,137	234,253	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	234,253	61,116	173,137	234,253	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	172,939	172,939		172,939	28.00
29.00	Low volume adjustment on or after October 1	70.97	545,122		545,122	545,122	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	1,933	-7,892	9,825	1,933	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	-5,039	-3,152	-1,887	-5,039	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	37,468	37,468	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0210	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/29/2021 2:19 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,655	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		7,662,511	2.00
3.00	OPPS payments		5,084,580	3.00
4.00	Outlier payment (see instructions)		1,776	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1,655	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		5,062	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)		5,062	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 charge basis 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)		5,062	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		3,407	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		1,655	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)		5,086,356	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)		1,000,790	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)		4,087,221	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)		4,087,221	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		4,087,221	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)		273,915	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		178,045	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		222,131	36.00
37.00	Subtotal (see instructions)		4,265,266	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)		4,265,266	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		4,269,328	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)		-4,062	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/29/2021 2:19 pm
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPSS (see instructions)		365	2.00
3.00	OPSS payments		173	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)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	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)		173	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)		35	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)		138	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)		138	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		138	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		138	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		138	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		138	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)		0	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: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/29/2021 2:19 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		4,697,187		4,269,328	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)		4,697,187		4,269,328	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		24,608		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		4,062	6.02	
7.00	Total Medicare program liability (see instructions)		4,721,795		4,265,266	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: 14-0210
 Component CCN: 14-S210

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 11/29/2021 2:19 pm

		Title XVIII		Subprovider - IPF		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						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		1,617,474		138		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)		0		0		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)		1,617,474		138		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		2,555		0		6.02
7.00	Total Medicare program liability (see instructions)		1,614,919		138		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: 14-0210

Period:

Worksheet E-1

Component CCN: 14-U210

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
11/29/2021 2:19 pm

		Title XVIII		Swing Beds - SNF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		114,716		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)		114,716		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		114,716		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: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/29/2021 2:19 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-0210

Period:

Worksheet E-2

Component CCN: 14-U210

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 2:19 pm

		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		118,221	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		207	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		118,221	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		118,221	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)		118,221	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		3,505	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		114,716	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		114,716	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		114,716	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)		0	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part II Date/Time Prepared: 11/29/2021 2:19 pm
		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)			1,715,984 1.00
2.00	Net IPF PPS Outlier Payments			1,419 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)			16.580822 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)			1,717,403 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)			1,717,403 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,717,403 18.00
19.00	Deductibles			167,660 19.00
20.00	Subtotal (line 18 minus line 19)			1,549,743 20.00
21.00	Coinsurance			26,400 21.00
22.00	Subtotal (line 20 minus line 21)			1,523,343 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			140,886 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			91,576 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			104,459 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,614,919 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
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,614,919 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			1,617,474 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)			-2,555 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			1,419 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

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

Provider CCN: 14-0210

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

Worksheet G

Date/Time Prepared:
11/29/2021 2:19 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	15,956,942	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	6,274,640	0	0	0	4.00
5.00	Other receivable	1,116,820	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,609,933	0	0	0	7.00
8.00	Prepaid expenses	822,394	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	25,780,729	0	0	0	11.00
FIXED ASSETS						
12.00	Land	772,443	0	0	0	12.00
13.00	Land improvements	672,089	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	38,287,123	0	0	0	15.00
16.00	Accumulated depreciation	-31,861,167	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	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	18,623,187	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	14,438	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	26,508,113	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,733,957	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	66,337	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,800,294	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	54,089,136	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,071,174	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,206,442	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	890,140	0	0	0	40.00
41.00	Deferred income	497,846	0	0	0	41.00
42.00	Accelerated payments	3,267,783	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	79,386	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,012,771	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	18,560,425	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18,560,425	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	28,573,196	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	25,515,940				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)	25,515,940	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	54,089,136	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0210

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

Worksheet G-1

Date/Time Prepared:
11/29/2021 2:19 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		18,701,838		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,814,102				2.00
3.00	Total (sum of line 1 and line 2)		25,515,940		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		25,515,940		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		25,515,940		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0210

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2021 2:19 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,261,025		2,261,025	1.00
2.00	SUBPROVIDER - IPF	8,118,286		8,118,286	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	163,340		163,340	5.00
6.00	Swing bed - NF	8,567		8,567	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	10,551,218		10,551,218	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,551,218		10,551,218	17.00
18.00	Ancillary services	10,208,837	78,304,235	88,513,072	18.00
19.00	Outpatient services	1,420,134	13,907,605	15,327,739	19.00
20.00	RURAL HEALTH CLINIC	0	2,398,601	2,398,601	20.00
20.01	RURAL HEALTH CLINIC II	0	2,628,469	2,628,469	20.01
20.02	RURAL HEALTH CLINIC III	0	3,043,266	3,043,266	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	1,204,885	1,803,357	3,008,242	27.00
27.01	PHYSICIAN CLINICS	0	926,440	926,440	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	23,385,074	103,011,973	126,397,047	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		56,075,164		29.00
30.00	FOUNDATION EXPENSES	69,845			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)		69,845		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)		56,145,009		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0210

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

Worksheet G-3

Date/Time Prepared:
11/29/2021 2:19 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	126,397,047	1.00
2.00	Less contractual allowances and discounts on patients' accounts	77,822,725	2.00
3.00	Net patient revenues (line 1 minus line 2)	48,574,322	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	56,145,009	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,570,687	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	2,075,506	6.00
7.00	Income from investments	222,129	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	101,563	22.00
23.00	Governmental appropriations	0	23.00
24.00	340B PHARMACY	964,674	24.00
24.01	MISCELLANEOUS INCOME	300,540	24.01
24.02	FOUNDATION REVENUE	76,542	24.02
24.50	COVID-19 PHE Funding	10,721,547	24.50
25.00	Total other income (sum of lines 6-24)	14,462,501	25.00
26.00	Total (line 5 plus line 25)	6,891,814	26.00
27.00	LOSS ON DISPOSAL OF ASSETS	77,712	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	77,712	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,814,102	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0210	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Prepared: 11/29/2021 2:19 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		234,253	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		5.13	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)		234,253	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: 14-0210

Period:

Worksheet M-1

Component CCN: 14-3473

From 07/01/2020

Date/Time Prepared:

To 06/30/2021

11/29/2021 2:19 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	476,326	0	476,326	-16,631	459,695
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	396,047	0	396,047	-7,093	388,954
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	197,715	0	197,715	0	197,715
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	206	0	206	-206	0
10.00	Subtotal (sum of lines 1 through 9)	1,070,294	0	1,070,294	-23,930	1,046,364
11.00	Physician Services Under Agreement	0	315,178	315,178	-26,442	288,736
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	315,178	315,178	-26,442	288,736
15.00	Medical Supplies	0	1,556	1,556	40,441	41,997
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	1,556	1,556	40,441	41,997
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,070,294	316,734	1,387,028	-9,931	1,377,097
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	71,336	71,336	-40,441	30,895
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	50,166	50,166
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	71,336	71,336	9,725	81,061
FACILITY OVERHEAD						
29.00	Facility Costs	0	37,787	37,787	-20,732	17,055
30.00	Administrative Costs	197,723	108,244	305,967	-17,979	287,988
31.00	Total Facility Overhead (sum of lines 29 and 30)	197,723	146,031	343,754	-38,711	305,043
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,268,017	534,101	1,802,118	-38,917	1,763,201

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-3473

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 2:19 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	459,695	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	388,954	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	197,715	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	1,046,364	10.00
11.00	Physician Services Under Agreement	0	288,736	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	288,736	14.00
15.00	Medical Supplies	0	41,997	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	41,997	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,377,097	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	30,895	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	50,166	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	81,061	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	17,055	29.00
30.00	Administrative Costs	0	287,988	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	305,043	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,763,201	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-8589

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 2:19 pm

				RHC II		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	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	502,156	0	502,156	-9,487	492,669	1.00
2.00	Physician Assistant	8,583	0	8,583	0	8,583	2.00
3.00	Nurse Practitioner	301,089	0	301,089	-10,736	290,353	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	154,911	0	154,911	0	154,911	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	966,739	0	966,739	-20,223	946,516	10.00
11.00	Physician Services Under Agreement	0	295,397	295,397	-21,662	273,735	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	295,397	295,397	-21,662	273,735	14.00
15.00	Medical Supplies	0	1,358	1,358	0	1,358	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,358	1,358	0	1,358	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	966,739	296,755	1,263,494	-41,885	1,221,609	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	104,042	104,042	0	104,042	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	41,885	41,885	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	104,042	104,042	41,885	145,927	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	24,060	24,060	-12,571	11,489	29.00
30.00	Administrative Costs	225,920	129,336	355,256	-5,909	349,347	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	225,920	153,396	379,316	-18,480	360,836	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,192,659	554,193	1,746,852	-18,480	1,728,372	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-8589

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 2:19 pm

		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	492,669	1.00
2.00	Physician Assistant	0	8,583	2.00
3.00	Nurse Practitioner	0	290,353	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	154,911	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	946,516	10.00
11.00	Physician Services Under Agreement	0	273,735	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	273,735	14.00
15.00	Medical Supplies	0	1,358	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,358	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,221,609	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	104,042	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	41,885	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	145,927	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	11,489	29.00
30.00	Administrative Costs	0	349,347	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	360,836	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,728,372	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-8590

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 2:19 pm

				RHC III		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	405,838	0	405,838	-4,514	401,324	1.00
2.00	Physician Assistant	195,008	0	195,008	-3,161	191,847	2.00
3.00	Nurse Practitioner	29,092	0	29,092	-379	28,713	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	137,083	0	137,083	0	137,083	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	767,021	0	767,021	-8,054	758,967	10.00
11.00	Physician Services Under Agreement	0	779,849	779,849	-58,235	721,614	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	779,849	779,849	-58,235	721,614	14.00
15.00	Medical Supplies	0	1,499	1,499	47,555	49,054	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,499	1,499	47,555	49,054	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	767,021	781,348	1,548,369	-18,734	1,529,635	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	181,834	181,834	-47,555	134,279	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	66,289	66,289	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	181,834	181,834	18,734	200,568	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	195,405	195,405	-183,252	12,153	29.00
30.00	Administrative Costs	325,434	149,612	475,046	-10,515	464,531	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	325,434	345,017	670,451	-193,767	476,684	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,092,455	1,308,199	2,400,654	-193,767	2,206,887	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-8590

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 2:19 pm

		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	401,324	1.00
2.00	Physician Assistant	0	191,847	2.00
3.00	Nurse Practitioner	0	28,713	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	137,083	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	758,967	10.00
11.00	Physician Services Under Agreement	0	721,614	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	721,614	14.00
15.00	Medical Supplies	0	49,054	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	49,054	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,529,635	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	134,279	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	66,289	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	200,568	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	12,153	29.00
30.00	Administrative Costs	0	464,531	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	476,684	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,206,887	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210

Period:

Worksheet M-2

Component CCN: 14-3473

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 2:19 pm

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.45	5,312	4,200	6,090		1.00
2.00	Physician Assistant	0.15	1,263	2,100	315		2.00
3.00	Nurse Practitioner	2.43	6,964	2,100	5,103		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.03	13,539		11,508	13,539	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)	4.03	13,539			13,539	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)					1,377,097	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					81,061	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,458,158	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.944409	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					305,043	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,589,874	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,894,917	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,894,917	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,789,577	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,166,674	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210

Period:

Worksheet M-2

Component CCN: 14-8589

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 2:19 pm

				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	1.02	4,687	4,200	4,284		1.00
2.00	Physician Assistant	0.42	3,228	2,100	882		2.00
3.00	Nurse Practitioner	1.21	5,384	2,100	2,541		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.65	13,299		7,707	13,299	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)	2.65	13,299			13,299	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)					1,221,609	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					145,927	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,367,536	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.893292	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					360,836	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,341,023	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,701,859	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,701,859	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,520,257	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,741,866	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210

Period:

Worksheet M-2

Component CCN: 14-8590

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 2:19 pm

				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	1.15	6,586	4,200	4,830		1.00
2.00	Physician Assistant	0.81	3,958	2,100	1,701		2.00
3.00	Nurse Practitioner	0.55	4,059	2,100	1,155		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.51	14,603		7,686	14,603	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)	2.51	14,603			14,603	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)					1,529,635	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					200,568	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,730,203	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.884078	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					476,684	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,527,906	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,004,590	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,004,590	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,772,214	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,301,849	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0210 Component CCN: 14-3473	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/29/2021 2:19 pm	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,166,674	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			99,648	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			3,067,026	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			13,539	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)			13,539	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			226.53	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	199.27	8.00
9.00	Rate for Program covered visits (see instructions)	226.53	226.53	199.27	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	2,985	0	1,078	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	676,192	0	214,813	11.00
12.00	Program covered visits for mental health services (from contractor records)	27	0	16	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	6,116	0	3,188	13.00
14.00	Limit adjustment for mental health services (see instructions)	6,116	0	3,188	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	900,309		16.00
16.01	Total program charges (see instructions)(from contractor's records)		675,572		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		54,876		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		73,131		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.)		614,580		16.04
16.05	Total program cost (see instructions)	0	687,711		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		58,953		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		112,348		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		687,711		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		59,153		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		746,864		22.00
23.00	Allowable bad debts (see instructions)		25,063		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		16,291		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		22,189		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)		763,155		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		573,177		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)		189,978		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: 14-0210 Component CCN: 14-8589	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/29/2021 2:19 pm	
		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)			2,741,866	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			143,756	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,598,110	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			13,299	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)			13,299	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			195.36	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	201.58	8.00
9.00	Rate for Program covered visits (see instructions)	195.36	195.36	195.36	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	2,380	0	857	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	464,957	0	167,424	11.00
12.00	Program covered visits for mental health services (from contractor records)	33	0	6	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	6,447	0	1,172	13.00
14.00	Limit adjustment for mental health services (see instructions)	6,447	0	1,172	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	640,000		16.00
16.01	Total program charges (see instructions)(from contractor's records)		665,573		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		123,344		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		118,605		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.)		371,178		16.04
16.05	Total program cost (see instructions)	0	489,783		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		57,422		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		96,961		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		489,783		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		57,201		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		546,984		22.00
23.00	Allowable bad debts (see instructions)		53,791		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		34,964		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		45,533		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)		581,948		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		507,342		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)		74,606		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: 14-0210 Component CCN: 14-8590	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/29/2021 2:19 pm	
		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)			3,301,849	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			113,431	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			3,188,418	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			14,603	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)			14,603	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			218.34	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor)	0.00	0.00	209.50	8.00
9.00	Rate for Program covered visits (see instructions)	218.34	218.34	209.50	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	2,665	0	935	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	581,876	0	195,883	11.00
12.00	Program covered visits for mental health services (from contractor records)	153	0	56	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	33,406	0	11,732	13.00
14.00	Limit adjustment for mental health services (see instructions)	33,406	0	11,732	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	822,897		16.00
16.01	Total program charges (see instructions)(from contractor's records)		742,073		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		104,616		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		116,010		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.)		512,156		16.04
16.05	Total program cost (see instructions)	0	628,166		16.05
17.00	Primary payer amounts		272		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		66,692		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		114,153		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		627,894		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		41,365		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		669,259		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)		669,259		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		582,439		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)		86,820		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: 14-0210

Period:

Worksheet M-4

Component CCN: 14-3473

From 07/01/2020

Date/Time Prepared:

To 06/30/2021

11/29/2021 2:19 pm

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,046,364	1,046,364	1,046,364	1,046,364	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000470	0.002294	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	492	2,400	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	16,956	23,486	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	17,448	25,886	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,377,097	1,377,097	1,377,097	1,377,097	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,789,577	1,789,577	1,789,577	1,789,577	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.012670	0.018798	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	22,674	33,640	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	40,122	59,526	0	0	10.00
11.00	Total number of injections/infusions (from your records)	112	546	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	358.23	109.02	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	72	306	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)	25,793	33,360	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)		99,648			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)		59,153			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0210

Period:

Worksheet M-4

Component CCN: 14-8589

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 2:19 pm

		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)	946,516	946,516	946,516	946,516	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001040	0.005580	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	984	5,282	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	23,346	34,437	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	24,330	39,719	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,221,609	1,221,609	1,221,609	1,221,609	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,520,257	1,520,257	1,520,257	1,520,257	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.019916	0.032514	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	30,277	49,430	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	54,607	89,149	0	0	10.00
11.00	Total number of injections/infusions (from your records)	162	869	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	337.08	102.59	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	86	275	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)	28,989	28,212	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)		143,756			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)		57,201			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0210

Period:

Worksheet M-4

Component CCN: 14-8590

From 07/01/2020

Date/Time Prepared:

To 06/30/2021

11/29/2021 2:19 pm

		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)	758,967	758,967	758,967	758,967	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000910	0.005670	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	691	4,303	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	17,223	30,332	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	17,914	34,635	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,529,635	1,529,635	1,529,635	1,529,635	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,772,214	1,772,214	1,772,214	1,772,214	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.011711	0.022643	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	20,754	40,128	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	38,668	74,763	0	0	10.00
11.00	Total number of injections/infusions (from your records)	119	739	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	324.94	101.17	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	56	229	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)	18,197	23,168	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)		113,431			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)		41,365			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0210 Component CCN: 14-3473	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/29/2021 2:19 pm
		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		573,177	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			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)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		573,177	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		189,978	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		763,155	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: 14-0210 Component CCN: 14-8589	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/29/2021 2:19 pm
		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		507,342	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			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)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		507,342	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		74,606	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		581,948	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: 14-0210 Component CCN: 14-8590	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/29/2021 2:19 pm
		RHC III	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		582,439	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			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)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		582,439	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		86,820	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		669,259	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00