

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: 14-0294	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/31/2022 9:40 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 5/31/2022	Time: 9:40 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CROSSROADS COMMUNITY HOSPITAL (14-0294) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Glenn Hargreaves	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Glenn Hargreaves		2
3	Signatory Title	SVP ACFO CAO TREASURER		3
4	Date	(Dated when report is electronica		4

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-177,018	7,560	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		32,677		0	10.00
10.01 RURAL HEALTH CLINIC II	0		-458,433		0	10.01
200.00 Total	0	-177,018	-418,196	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: 14-0294		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 9:40 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 8 DOCTORS PARK ROAD			PO Box:				1.00		
2.00	City: MT VERNON			State: IL		Zip Code: 62864		County: JEFFERSON		
		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		CROSSROADS COMMUNITY HOSPITAL	140294	99914	1	07/01/1966	N	P	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		CROSSROADS COMMUNITY HOSPITAL	14U294	99914		04/12/1989	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		CROSSROADS FAMILY MED OF MT. VERNON	148523	99914		07/19/2013	N	O	N
15.01	Hospital-Based Health Clinic - RHC I		CROSSROADS FAMILY MED OF WAYNE CITY	148605	99914		11/20/2019	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)						01/01/2021	12/31/2021		20.00
21.00	Type of Control (see instructions)						4			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 OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
5/31/2022 9:40 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	47	0	0	0	209	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.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					1		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.					01/01/2021	12/31/2021	38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	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.							
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.							
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: 14-0294		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 9:40 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
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: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
5/31/2022 9:40 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
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.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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			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 1.00	XIX 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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
		Physical 1.00	Occupational 2.00	Speech 3.00
		Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			109.00
			1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0294	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 9:40 am
		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.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	148,875	-2,282	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	Y	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)	Y	HB0776	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0294		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 9:40 am		
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: QUORUM GROUP CORPORATION		Contractor's Name: WISCONSIN PHYSICIAN SERVICES		Contractor's Number: 52280				141.00	
142.00	Street: 1573 MALLORY LANE		PO Box: SUITE 100						142.00	
143.00	City: BRENTWOOD		State: TN		Zip Code: 37027				143.00	
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00		
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.					Y	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.					N			146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	N	N		155.00	
156.00	Subprovider - IPF			N	N	N	N		156.00	
157.00	Subprovider - IRF			N	N	N	N		157.00	
158.00	SUBPROVIDER								158.00	
159.00	SNF			N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY			N	N	N	N		160.00	
161.00	CMHC				N	N	N		161.00	
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus	
				0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								9.99	169.00
								Beginning	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: 14-0294		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part II Date/Time Prepared: 5/31/2022 9:40 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
					Y/N		
					1.00		
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	04/13/2022	Y	04/13/2022
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
5/31/2022 9:40 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		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.		Y		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.	WHITE	CHRIS		41.00
42.00	Enter the employer/company name of the cost report preparer	QHC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 221-3792	CWHITE@QHCUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
5/31/2022 9:40 am

		3.00			
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VP REVENUE MANAGEMENT			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: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/31/2022 9:40 am

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	40	14,600	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)		40	14,600	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	7	2,555	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		47	17,155	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						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						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
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		47				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: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/31/2022 9:40 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,063	47	2,003			1.00
2.00	HMO and other (see instructions)	10	209				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,063	47	2,003			7.00
8.00	INTENSIVE CARE UNIT	35	0	120			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)	1,098	47	2,123	0.00	164.31	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,703	0	3,586	0.00	2.68	26.00
26.01	RURAL HEALTH CLINIC II	4,222	0	18,125	0.00	17.20	26.01
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	184.19	27.00
28.00	Observation Bed Days		0	435			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: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/31/2022 9:40 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	337	18	751	1.00
2.00 HMO and other (see instructions)			3	82		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	337	18	751	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						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
26.25 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: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
5/31/2022 9:40 am

	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	12,662,562	0	12,662,562	383,116.00	33.05
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
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		477,501	0	477,501	4,160.00	114.78
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		1,253,862	0	1,253,862	39,272.00	31.93
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)		23,389	90,909	114,298	3,094.00	36.94
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		493,801	0	493,801	4,101.00	120.41
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		8,400	0	8,400	120.00	70.00
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		767,892	0	767,892	9,901.00	77.56
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)		2,646,999	0	2,646,999		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		26,160	0	26,160		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		45,827	0	45,827		
24.00	Wage-related costs (RHC/FQHC)		315,738	0	315,738		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		64,331	0	64,331		
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: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
5/31/2022 9:40 am

		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	191,233	0	191,233	5,915.00	32.33	26.00
27.00	Administrative & General	5.00	1,390,629	-90,909	1,299,720	31,150.00	41.72	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	424,219	0	424,219	19,745.00	21.48	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	405,624	0	405,624	26,944.00	15.05	32.00
33.00	Housekeeping under contract (see instructions)		10,236	0	10,236	650.00	15.75	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		839,339	0	839,339	52,019.00	16.14	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	899,893	0	899,893	20,998.00	42.86	38.00
39.00	Central Services and Supply	14.00	248,041	0	248,041	12,368.00	20.06	39.00
40.00	Pharmacy	15.00	442,465	0	442,465	6,961.00	63.56	40.00
41.00	Medical Records & Medical Records Library	16.00	445	0	445	15.00	29.67	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part III
Date/Time Prepared:
5/31/2022 9:40 am

	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)	11,780,774	0	11,780,774	392,353.00	30.03	1.00
2.00	Excluded area salaries (see instructions)	23,389	90,909	114,298	3,094.00	36.94	2.00
3.00	Subtotal salaries (line 1 minus line 2)	11,757,385	-90,909	11,666,476	389,259.00	29.97	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,270,093	0	1,270,093	14,122.00	89.94	4.00
5.00	Subtotal wage-related costs (see inst.)	2,711,330	0	2,711,330	0.00	23.24	5.00
6.00	Total (sum of lines 3 thru 5)	15,738,808	-90,909	15,647,899	403,381.00	38.79	6.00
7.00	Total overhead cost (see instructions)	4,852,124	-90,909	4,761,215	176,765.00	26.94	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part IV
Date/Time Prepared:
5/31/2022 9:40 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	79,824	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,762,663	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	11,612	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	7,421	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-79	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	10,516	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	227,996	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	719,357	17.00
18.00	Medicare Taxes - Employers Portion Only	168,237	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	53,123	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,040,670	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: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part V
Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	493,801	3,040,670	1.00
2.00	Hospital	493,801	3,040,670	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

Health Financial Systems		CROSSROADS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0294 Component CCN: 14-8523		Period: From 01/01/2021 To 12/31/2021
			Worksheet S-8		Date/Time Prepared: 5/31/2022 9:40 am
			RHC I		Cost
			1.00		
1.00	Clinic Address and Identification				
	Street		1209 WEST ROBINSON		1.00
			City	State	ZIP Code
			1.00	2.00	3.00
2.00	City, State, ZIP Code, County		WAYNE CITY IL 62895		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
			1.00	2.00	3.00
Facility hours of operations (1)			Tuesday		
11.00	CLINIC		07:30 17:00		07:30 11.00
			1.00		2.00
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		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
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		15.00		
			County		
			4.00		
2.00	City, State, ZIP Code, County		WAYNE		2.00
			Tuesday		Wednesday
			to	from	to
			6.00	7.00	8.00
Facility hours of operations (1)			Thursday		
11.00	CLINIC		17:00 07:30 17:00 07:30 17:00		11.00

Health Financial Systems		CROSSROADS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0294	Period: From 01/01/2021	Worksheet S-8
			Component CCN: 14-8523	To 12/31/2021	Date/Time Prepared: 5/31/2022 9:40 am
			RHC I		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	07:30	17:00		11.00

Health Financial Systems		CROSSROADS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0294 Component CCN: 14-8605		Period: From 01/01/2021 To 12/31/2021
			Worksheet S-8		Date/Time Prepared: 5/31/2022 9:40 am
			RHC II		Cost
			1.00		
1.00	Clinic Address and Identification				
	Street		4101 NORTH WATER TOWER PLACE		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		MT VERNON IL 62864		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		Tuesday
			1.00 2.00		from
			3.00 4.00		5.00
Facility hours of operations (1)					
11.00	CLINIC		07:30 17:00		07:30 11.00
			1.00		2.00
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N 0		13.00
			Provider name		CCN number
			1.00		2.00
14.00	RHC/FQHC name, CCN number		14.00		
			Y/N		V
			1.00		2.00
			XVIII		XIX
			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		JEFFERSON		2.00
			Tuesday		Wednesday
			to		to
			6.00 7.00		8.00 9.00
			10.00		
Facility hours of operations (1)					
11.00	CLINIC		17:00 07:30		17:00 11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0294 Component CCN: 14-8605		Period: From 01/01/2021 To 12/31/2021		Worksheet S-8 Date/Time Prepared: 5/31/2022 9:40 am	
						RHC II		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC			07:30	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0294	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/31/2022 9:40 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.147393		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,477,560		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		254,125		5.00
6.00	Medicaid charges		4,212,201		6.00
7.00	Medicaid cost (line 1 times line 6)		620,849		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)		0		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0		9.00
10.00	Stand-alone CHIP charges		0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0		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)	2,169,303	4,040	2,173,343	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	319,740	4,040	323,780	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)	319,740	4,040	323,780	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		4,047,164		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		216,400		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		332,923		27.01
28.00	Non-Medicare bad debt expense (see instructions)		3,714,241		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		663,976		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		987,756		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		987,756		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES					Provider CCN: 14-0294	Period: From 01/01/2021 To 12/31/2021	Worksheet A Date/Time Prepared: 5/31/2022 9:40 am	
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		207,923	207,923	417,497	625,420	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,391,969	1,391,969	5,358	1,397,327	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	191,233	36,921	228,154	2,253,588	2,481,742	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,390,629	16,259,945	17,650,574	-2,649,921	15,000,653	5.00
7.00	00700	OPERATION OF PLANT	424,219	878,540	1,302,759	84,421	1,387,180	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	84,186	84,186	0	84,186	8.00
9.00	00900	HOUSEKEEPING	405,624	80,986	486,610	0	486,610	9.00
10.00	01000	DIETARY	0	643,701	643,701	-373,296	270,405	10.00
11.00	01100	CAFETERIA	0	0	0	373,296	373,296	11.00
13.00	01300	NURSING ADMINISTRATION	899,893	121,012	1,020,905	0	1,020,905	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	248,041	436,287	684,328	-198,549	485,779	14.00
15.00	01500	PHARMACY	442,465	1,261,574	1,704,039	-1,116,591	587,448	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	445	116,676	117,121	0	117,121	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	942,386	1,111,852	2,054,238	0	2,054,238	30.00
31.00	03100	INTENSIVE CARE UNIT	502,702	393,838	896,540	0	896,540	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,990,420	6,982,231	8,972,651	-2,611,564	6,361,087	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	4	1,207,360	1,207,364	0	1,207,364	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	508,943	487,192	996,135	0	996,135	54.00
54.01	03630	ULTRA SOUND	145,838	122,470	268,308	0	268,308	54.01
56.00	05600	RADIOISOTOPE	3,498	171,066	174,564	0	174,564	56.00
57.00	05700	CT SCAN	143,810	199,740	343,550	0	343,550	57.00
58.00	05800	MRI	36,184	340,404	376,588	0	376,588	58.00
60.00	06000	LABORATORY	655,197	804,764	1,459,961	0	1,459,961	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	341,717	81,390	423,107	0	423,107	65.00
66.00	06600	PHYSICAL THERAPY	303,948	107,353	411,301	-19,154	392,147	66.00
67.00	06700	OCCUPATIONAL THERAPY	91,724	8,123	99,847	18,583	118,430	67.00
68.00	06800	SPEECH PATHOLOGY	45,965	3,275	49,240	571	49,811	68.00
69.00	06900	ELECTROCARDIOLOGY	173,726	71,229	244,955	0	244,955	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	183,851	183,851	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,541,841	2,541,841	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,116,591	1,116,591	73.00
74.00	07400	RENAL DIALYSIS	0	24,000	24,000	0	24,000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	96,720	31,800	128,520	0	128,520	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	222,031	183,966	405,997	-48,049	357,948	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,264,632	867,760	2,132,392	-265,452	1,866,940	88.01
91.00	09100	EMERGENCY	1,167,179	1,415,692	2,582,871	-39,254	2,543,617	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,639,173	36,135,225	48,774,398	-326,233	48,448,165	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	64,057	64,057	0	64,057	192.00
194.00	07955	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	326,233	326,233	194.01
194.02	07954	SENIOR CIRCLE	23,389	15,509	38,898	0	38,898	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	12,662,562	36,214,791	48,877,353	0	48,877,353	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0294

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

Worksheet A

Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-153,336	472,084	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	28,153	1,425,480	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,481,742	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,809,210	10,191,443	5.00
7.00	00700	OPERATION OF PLANT	-8,586	1,378,594	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	84,186	8.00
9.00	00900	HOUSEKEEPING	0	486,610	9.00
10.00	01000	DIETARY	0	270,405	10.00
11.00	01100	CAFETERIA	-53,093	320,203	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,020,905	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	485,779	14.00
15.00	01500	PHARMACY	0	587,448	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	117,121	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-592,845	1,461,393	30.00
31.00	03100	INTENSIVE CARE UNIT	-648,244	248,296	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-275,620	6,085,467	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	-1,130,413	76,951	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-22,980	973,155	54.00
54.01	03630	ULTRA SOUND	-2,065	266,243	54.01
56.00	05600	RADIOISOTOPE	-210	174,354	56.00
57.00	05700	CT SCAN	-31,326	312,224	57.00
58.00	05800	MRI	0	376,588	58.00
60.00	06000	LABORATORY	0	1,459,961	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	423,107	65.00
66.00	06600	PHYSICAL THERAPY	0	392,147	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	118,430	67.00
68.00	06800	SPEECH PATHOLOGY	0	49,811	68.00
69.00	06900	ELECTROCARDIOLOGY	0	244,955	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	183,851	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,541,841	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,116,591	73.00
74.00	07400	RENAL DIALYSIS	0	24,000	74.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.01	03610	SLEEP LAB	0	128,520	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	357,948	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,866,940	88.01
91.00	09100	EMERGENCY	-893,160	1,650,457	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,592,935	39,855,230	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	64,057	192.00
194.00	07955	OTHER NRCC	0	0	194.00
194.01	07951	MARKETING	0	326,233	194.01
194.02	07954	SENIOR CIRCLE	0	38,898	194.02
194.03	07953	VACANT SPACE	0	0	194.03
194.04	07952	GUEST MEALS	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,592,935	40,284,418	200.00

RECLASSIFICATIONS

Provider CCN: 14-0294

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

Worksheet A-6

Date/Time Prepared:
5/31/2022 9:40 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,253,588	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
	0		0	2,253,588		
	B - OXYGEN SUPPLY					
1.00	OPERATION OF PLANT	7.00	0	84,421	1.00	
	0		0	84,421		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	100,995	1.00	
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	316,502	2.00	
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,358	3.00	
	0		0	422,855		
	E - MARKETING					
1.00	MARKETING	194.01	90,909	235,324	1.00	
	0		90,909	235,324		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	268,272	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,541,841	2.00	
	0		0	2,810,113		
	G - COST OF DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,116,591	1.00	
	0		0	1,116,591		
	J - DIETARY					
1.00	CAFETERIA	11.00	0	373,296	1.00	
	0		0	373,296		
	K - RECLASS SPEECH THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	0	18,583	1.00	
2.00	SPEECH PATHOLOGY	68.00	0	571	2.00	
	0		0	19,154		
	L - ATHENA BILLING AND COLLECTION SVCS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	193,172	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
	0		0	193,172		
500.00	Grand Total: Increases		90,909	7,508,514	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0294

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

Worksheet A-6

Date/Time Prepared:
5/31/2022 9:40 am

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
	A - EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,094,005	119	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	22,725	0	2.00
3.00	RURAL HEALTH CLINIC II	88.01	0	119,224	0	3.00
4.00	EMERGENCY	91.00	0	17,634	0	4.00
			0	2,253,588		
	B - OXYGEN SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	84,421	0	1.00
			0	84,421		
	D - OTHER CAPITAL COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	422,855	12	1.00
2.00		0.00	0	0	13	2.00
3.00		0.00	0	0	12	3.00
			0	422,855		
	E - MARKETING					
1.00	ADMINISTRATIVE & GENERAL	5.00	90,909	235,324	0	1.00
			90,909	235,324		
	F - MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	198,549	0	1.00
2.00	OPERATING ROOM	50.00	0	2,611,564	0	2.00
			0	2,810,113		
	G - COST OF DRUGS					
1.00	PHARMACY	15.00	0	1,116,591	0	1.00
			0	1,116,591		
	J - DIETARY					
1.00	DIETARY	10.00	0	373,296	0	1.00
			0	373,296		
	K - RECLASS SPEECH THERAPY					
1.00	PHYSICAL THERAPY	66.00	0	19,154	0	1.00
2.00		0.00	0	0	0	2.00
			0	19,154		
	L - ATHENA BILLING AND COLLECTION SVCS					
1.00	RURAL HEALTH CLINIC	88.00	0	25,324	0	1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	146,228	0	2.00
3.00	EMERGENCY	91.00	0	21,620	0	3.00
			0	193,172		
500.00	Grand Total: Decreases		90,909	7,508,514		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part I
Date/Time Prepared:
5/31/2022 9:40 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	1,640,000	0	0	0	0	1.00	
2.00	Land Improvements	162,111	0	0	0	0	2.00	
3.00	Buildings and Fixtures	6,697,204	0	0	0	0	3.00	
4.00	Building Improvements	37,301	40,427	0	40,427	0	4.00	
5.00	Fixed Equipment	185,874	2,245	0	2,245	0	5.00	
6.00	Movable Equipment	2,551,873	2,364,452	0	2,364,452	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	11,274,363	2,407,124	0	2,407,124	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	11,274,363	2,407,124	0	2,407,124	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	1,640,000	0					1.00
2.00	Land Improvements	162,111	0					
3.00	Buildings and Fixtures	6,697,204	0					
4.00	Building Improvements	77,728	0					4.00
5.00	Fixed Equipment	188,119	0					
6.00	Movable Equipment	4,916,325	0					
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	13,681,487	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	13,681,487	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part II
Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	207,923	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,391,969	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,599,892	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	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	207,923				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,391,969				2.00
3.00	Total (sum of lines 1-2)	0	1,599,892				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part III
Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	6,963,052	0	6,963,052	0.586146	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,916,324	0	4,916,324	0.413854	0	2.00
3.00	Total (sum of lines 1-2)	11,879,376	0	11,879,376	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	294,171	-239,584	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,420,122	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,714,293	-239,584	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	100,995	316,502	0	472,084	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,358	0	0	1,425,480	2.00
3.00	Total (sum of lines 1-2)	0	106,353	316,502	0	1,897,564	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0294

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

Worksheet A-8

Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		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	-126,866	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,595,853			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-1,010	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,654,985			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-53,093	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	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	ADMIN & GENERAL ORGANIZATION COST	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MARKETING EXPENSE	A	-152,192	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0294

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

Worksheet A-8

Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.02	HEALTH WOMAN SPONSORSHIP	B		0ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	COUNTRY CLUB DUES	A	-800	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PHYSICIAN RECRUITING	A	1,186	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	LOBBYING EXPENSE	A	-3,348	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PENALTIES	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	SPECIAL EVENTS	A	-7,087	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MEDICAL STAFF RELATIONS	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	ILLINOIS PROVIDER TAX	A	-2,543,664	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	GIFT SHOP EXPENSE	A	-136	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	NON-ALLOWABLE LEGAL FEES	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.13	TELEPHONE BENEFIT COSTS	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	TELEPHONE DEPRECIATION COST	A	-2,821	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.14
33.15	TELEVISION EXPENSE	A	-8,586	OPERATION OF PLANT	7.00	0	33.15
33.21	RENTAL INCOME	B	-239,584	CAP REL COSTS-BLDG & FIXT	1.00	10	33.21
33.22	OTHER MISCELLANEOUS REVENUE	B	-204,096	ADMINISTRATIVE & GENERAL	5.00	0	33.22
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,592,935				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0294

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

Worksheet A-8-1

Date/Time Prepared:
5/31/2022 9:40 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE BLDG & FIXED	86,248	0
2.00		0.00			0	0
3.00		2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE MME	30,974	0
4.00		0.00			0	0
4.01		5.00	ADMINISTRATIVE & GENERAL	POOLED NON-CAPITAL COSTS	658,683	1,940,487
4.02		5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	146,593	636,996
5.00					922,498	2,577,483
	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.					

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership
	1.00	2.00	3.00	4.00	5.00
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

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

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

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

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

Provider CCN: 14-0294

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

Worksheet A-8-1

Date/Time Prepared:
5/31/2022 9:40 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	86,248	9		1.00
2.00	0	0		2.00
3.00	30,974	9		3.00
4.00	0	0		4.00
4.01	-1,281,804	0		4.01
4.02	-490,403	0		4.02
5.00	-1,654,985			5.00

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

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

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

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

6.00	HOSPITAL MGMT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0294

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

Worksheet A-8-2

Date/Time Prepared:
5/31/2022 9:40 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	0.00		0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	592,845	592,845	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	648,244	648,244	0	0	0	3.00
4.00	50.00	OPERATING ROOM	275,620	275,620	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	21,970	21,970	0	0	0	5.00
6.00	54.01	ULTRA SOUND	2,065	2,065	0	0	0	6.00
7.00	56.00	RADIOISOTOPE	210	210	0	0	0	7.00
8.00	57.00	CT SCAN	31,326	31,326	0	0	0	8.00
9.00	60.00	LABORATORY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	893,160	893,160	0	0	0	10.00
11.00	53.00	ANESTHESIOLOGY	1,130,413	1,130,413	0	0	0	11.00
200.00			3,595,853	3,595,853	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	0.00		0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	54.01	ULTRA SOUND	0	0	0	0	0	6.00
7.00	56.00	RADIOISOTOPE	0	0	0	0	0	7.00
8.00	57.00	CT SCAN	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
11.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	11.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	0.00		0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	592,845		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	648,244		3.00
4.00	50.00	OPERATING ROOM	0	0	0	275,620		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	21,970		5.00
6.00	54.01	ULTRA SOUND	0	0	0	2,065		6.00
7.00	56.00	RADIOISOTOPE	0	0	0	210		7.00
8.00	57.00	CT SCAN	0	0	0	31,326		8.00
9.00	60.00	LABORATORY	0	0	0	0		9.00
10.00	91.00	EMERGENCY	0	0	0	893,160		10.00
11.00	53.00	ANESTHESIOLOGY	0	0	0	1,130,413		11.00
200.00			0	0	0	3,595,853		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	472,084	472,084			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,425,480		1,425,480		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,481,742	3,018	9,113	2,493,873	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,191,443	50,424	152,259	259,904	5.00
7.00	00700	OPERATION OF PLANT	1,378,594	92,279	278,638	84,831	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	84,186	2,069	6,249	0	8.00
9.00	00900	HOUSEKEEPING	486,610	15,558	46,979	81,112	9.00
10.00	01000	DIETARY	270,405	14,539	43,900	0	10.00
11.00	01100	CAFETERIA	320,203	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,020,905	4,814	14,535	179,951	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	485,779	10,280	31,040	49,601	14.00
15.00	01500	PHARMACY	587,448	3,817	11,524	88,479	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	117,121	9,350	28,233	89	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,461,393	85,223	257,334	188,448	30.00
31.00	03100	INTENSIVE CARE UNIT	248,296	18,007	54,372	100,525	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,085,467	57,900	174,831	398,014	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	76,951	641	1,936	1	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	973,155	16,289	49,187	101,773	54.00
54.01	03630	ULTRA SOUND	266,243	1,908	5,762	29,163	54.01
56.00	05600	RADIOISOTOPE	174,354	1,601	4,834	699	56.00
57.00	05700	CT SCAN	312,224	0	0	28,758	57.00
58.00	05800	MRI	376,588	0	0	7,236	58.00
60.00	06000	LABORATORY	1,459,961	11,198	33,814	131,019	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	570	1,721	0	62.00
65.00	06500	RESPIRATORY THERAPY	423,107	5,121	15,464	68,333	65.00
66.00	06600	PHYSICAL THERAPY	392,147	2,066	6,238	60,780	66.00
67.00	06700	OCCUPATIONAL THERAPY	118,430	0	0	18,342	67.00
68.00	06800	SPEECH PATHOLOGY	49,811	0	0	9,192	68.00
69.00	06900	ELECTROCARDIOLOGY	244,955	0	0	34,740	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	183,851	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,541,841	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,116,591	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	24,000	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	128,520	0	0	19,341	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	357,948	0	0	44,399	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,866,940	0	0	252,887	88.01
91.00	09100	EMERGENCY	1,650,457	23,551	71,114	233,400	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,855,230	430,223	1,299,077	2,471,017	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,443	4,358	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	64,057	1,402	4,234	0	192.00
194.00	07955	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	326,233	769	2,321	18,179	194.01
194.02	07954	SENIOR CIRCLE	38,898	2,024	6,113	4,677	194.02
194.03	07953	VACANT SPACE	0	36,223	109,377	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	194.04
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)	40,284,418	472,084	1,425,480	2,493,873	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,654,030					5.00
7.00	00700	OPERATION OF PLANT	659,563	2,493,905				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,261	15,814	141,579			8.00
9.00	00900	HOUSEKEEPING	226,618	118,890	0	975,767		9.00
10.00	01000	DIETARY	118,240	111,097	0	45,950	604,131	10.00
11.00	01100	CAFETERIA	115,133	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	438,742	36,784	0	15,214	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	207,361	78,553	0	32,490	0	14.00
15.00	01500	PHARMACY	248,555	29,164	0	12,062	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55,658	71,448	0	29,551	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	716,395	651,228	46,722	269,349	564,276	30.00
31.00	03100	INTENSIVE CARE UNIT	151,448	137,597	8,494	56,910	33,806	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,414,919	442,442	28,317	182,994	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	28,596	4,899	0	2,026	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	410,048	124,476	8,494	51,483	0	54.00
54.01	03630	ULTRA SOUND	108,975	14,582	0	6,031	0	54.01
56.00	05600	RADIOISOTOPE	65,257	12,233	0	5,059	0	56.00
57.00	05700	CT SCAN	122,605	0	0	0	0	57.00
58.00	05800	MRI	138,009	0	0	0	0	58.00
60.00	06000	LABORATORY	588,244	85,572	0	35,393	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	824	4,355	0	1,801	0	62.00
65.00	06500	RESPIRATORY THERAPY	184,106	39,133	4,247	16,186	0	65.00
66.00	06600	PHYSICAL THERAPY	165,842	15,785	0	6,529	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,178	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	21,215	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	100,568	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	66,106	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	913,955	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	401,486	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	8,630	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	53,165	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	144,669	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	762,213	0	0	0	0	88.01
91.00	09100	EMERGENCY	711,405	179,968	45,305	74,435	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,430,989	2,174,020	141,579	843,463	598,082	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,086	11,030	0	4,562	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,059	10,714	0	4,431	0	192.00
194.00	07955	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	124,949	5,873	0	2,429	0	194.01
194.02	07954	SENIOR CIRCLE	18,594	15,470	0	6,398	0	194.02
194.03	07953	VACANT SPACE	52,353	276,798	0	114,484	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	6,049	194.04
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)	10,654,030	2,493,905	141,579	975,767	604,131	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/31/2022 9:40 am

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	435,336					11.00
13.00	01300	NURSING ADMINISTRATION	30,547	1,741,492				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,995	0	913,099			14.00
15.00	01500	PHARMACY	10,132	101,489	4,691	1,097,361		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30	0	6	0	311,486	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	40,981	216,157	16,397	0	6,740	30.00
31.00	03100	INTENSIVE CARE UNIT	7,168	115,306	2,500	0	281	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	88,586	456,550	370,941	0	76,146	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	12,279	0	34,428	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,278	116,737	3,197	0	10,495	54.00
54.01	03630	ULTRA SOUND	5,777	33,451	1,877	0	3,416	54.01
56.00	05600	RADIOISOTOPE	151	802	268	0	2,027	56.00
57.00	05700	CT SCAN	7,773	32,986	5,413	0	36,875	57.00
58.00	05800	MRI	1,694	8,300	352	0	5,221	58.00
60.00	06000	LABORATORY	38,078	150,284	13,749	0	47,124	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	666	62.00
65.00	06500	RESPIRATORY THERAPY	15,152	78,380	4,692	0	3,277	65.00
66.00	06600	PHYSICAL THERAPY	14,003	69,717	2,362	0	6,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,446	21,039	185	0	2,083	67.00
68.00	06800	SPEECH PATHOLOGY	1,815	10,543	0	0	300	68.00
69.00	06900	ELECTROCARDIOLOGY	11,946	39,848	333	0	5,354	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	42,390	0	903	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	402,565	0	29,266	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,097,361	9,684	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	69	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	4,234	22,185	3,273	0	1,393	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	8,105	0	2,490	0	803	88.00
88.01	08801	RURAL HEALTH CLINIC II	52,020	0	7,179	0	4,101	88.01
91.00	09100	EMERGENCY	41,919	267,718	13,688	0	23,955	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	430,830	1,741,492	910,827	1,097,361	311,486	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07955	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	2,964	0	836	0	0	194.01
194.02	07954	SENIOR CIRCLE	1,542	0	1,436	0	0	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
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)	435,336	1,741,492	913,099	1,097,361	311,486	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,520,643	0	4,520,643	30.00
31.00	03100	INTENSIVE CARE UNIT	934,710	0	934,710	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,777,107	0	10,777,107	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	161,757	0	161,757	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,893,612	0	1,893,612	54.00
54.01	03630	ULTRA SOUND	477,185	0	477,185	54.01
56.00	05600	RADIOISOTOPE	267,285	0	267,285	56.00
57.00	05700	CT SCAN	546,634	0	546,634	57.00
58.00	05800	MRI	537,400	0	537,400	58.00
60.00	06000	LABORATORY	2,594,436	0	2,594,436	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,937	0	9,937	62.00
65.00	06500	RESPIRATORY THERAPY	857,198	0	857,198	65.00
66.00	06600	PHYSICAL THERAPY	742,348	0	742,348	66.00
67.00	06700	OCCUPATIONAL THERAPY	213,703	0	213,703	67.00
68.00	06800	SPEECH PATHOLOGY	92,876	0	92,876	68.00
69.00	06900	ELECTROCARDIOLOGY	437,744	0	437,744	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	293,250	0	293,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,887,627	0	3,887,627	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,625,122	0	2,625,122	73.00
74.00	07400	RENAL DIALYSIS	32,699	0	32,699	74.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03610	SLEEP LAB	232,111	0	232,111	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	558,414	0	558,414	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,945,340	0	2,945,340	88.01
91.00	09100	EMERGENCY	3,336,915	0	3,336,915	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,976,053	0	38,976,053	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,479	0	23,479	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	109,897	0	109,897	192.00
194.00	07955	OTHER NRCC	0	0	0	194.00
194.01	07951	MARKETING	484,553	0	484,553	194.01
194.02	07954	SENIOR CIRCLE	95,152	0	95,152	194.02
194.03	07953	VACANT SPACE	589,235	0	589,235	194.03
194.04	07952	GUEST MEALS	6,049	0	6,049	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	40,284,418	0	40,284,418	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,018	9,113	12,131	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	50,424	152,259	202,683	5.00
7.00	00700	OPERATION OF PLANT	0	92,279	278,638	370,917	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,069	6,249	8,318	8.00
9.00	00900	HOUSEKEEPING	0	15,558	46,979	62,537	9.00
10.00	01000	DIETARY	0	14,539	43,900	58,439	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,814	14,535	19,349	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,280	31,040	41,320	14.00
15.00	01500	PHARMACY	0	3,817	11,524	15,341	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,350	28,233	37,583	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	85,223	257,334	342,557	30.00
31.00	03100	INTENSIVE CARE UNIT	0	18,007	54,372	72,379	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	57,900	174,831	232,731	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	641	1,936	2,577	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,289	49,187	65,476	54.00
54.01	03630	ULTRA SOUND	0	1,908	5,762	7,670	54.01
56.00	05600	RADIOISOTOPE	0	1,601	4,834	6,435	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	11,198	33,814	45,012	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	570	1,721	2,291	62.00
65.00	06500	RESPIRATORY THERAPY	0	5,121	15,464	20,585	65.00
66.00	06600	PHYSICAL THERAPY	0	2,066	6,238	8,304	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	23,551	71,114	94,665	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	430,223	1,299,077	1,729,300	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,443	4,358	5,801	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,402	4,234	5,636	192.00
194.00	07955	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	0	769	2,321	3,090	194.01
194.02	07954	SENIOR CIRCLE	0	2,024	6,113	8,137	194.02
194.03	07953	VACANT SPACE	0	36,223	109,377	145,600	194.03
194.04	07952	GUEST MEALS	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	472,084	1,425,480	1,897,564	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	203,948					5.00
7.00	00700	OPERATION OF PLANT	12,626	383,956				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	637	2,435	11,390			8.00
9.00	00900	HOUSEKEEPING	4,338	18,304	0	85,574		9.00
10.00	01000	DIETARY	2,263	17,104	0	4,030	81,836	10.00
11.00	01100	CAFETERIA	2,204	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,399	5,663	0	1,334	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,969	12,094	0	2,849	0	14.00
15.00	01500	PHARMACY	4,758	4,490	0	1,058	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,065	11,000	0	2,592	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,714	100,264	3,759	23,621	76,438	30.00
31.00	03100	INTENSIVE CARE UNIT	2,899	21,184	683	4,991	4,579	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	46,232	68,117	2,278	16,048	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	547	754	0	178	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,849	19,164	683	4,515	0	54.00
54.01	03630	ULTRA SOUND	2,086	2,245	0	529	0	54.01
56.00	05600	RADIOISOTOPE	1,249	1,883	0	444	0	56.00
57.00	05700	CT SCAN	2,347	0	0	0	0	57.00
58.00	05800	MRI	2,642	0	0	0	0	58.00
60.00	06000	LABORATORY	11,261	13,174	0	3,104	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	16	670	0	158	0	62.00
65.00	06500	RESPIRATORY THERAPY	3,524	6,025	342	1,419	0	65.00
66.00	06600	PHYSICAL THERAPY	3,175	2,430	0	573	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	941	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	406	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,925	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,265	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,495	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,685	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	165	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,018	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,769	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	14,591	0	0	0	0	88.01
91.00	09100	EMERGENCY	13,618	27,707	3,645	6,528	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	199,678	334,707	11,390	73,971	81,017	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	40	1,698	0	400	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	480	1,650	0	389	0	192.00
194.00	07955	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	2,392	904	0	213	0	194.01
194.02	07954	SENIOR CIRCLE	356	2,382	0	561	0	194.02
194.03	07953	VACANT SPACE	1,002	42,615	0	10,040	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	819	194.04
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)	203,948	383,956	11,390	85,574	81,836	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/31/2022 9:40 am

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	2,204					11.00
13.00	01300	NURSING ADMINISTRATION	155	35,776				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	91	0	60,564			14.00
15.00	01500	PHARMACY	51	2,085	311	28,525		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	52,240	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	207	4,441	1,088	0	1,133	30.00
31.00	03100	INTENSIVE CARE UNIT	36	2,369	166	0	47	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	450	9,379	24,603	0	12,683	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	814	0	5,787	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	143	2,398	212	0	1,764	54.00
54.01	03630	ULTRA SOUND	29	687	124	0	574	54.01
56.00	05600	RADIOISOTOPE	1	16	18	0	341	56.00
57.00	05700	CT SCAN	39	678	359	0	6,198	57.00
58.00	05800	MRI	9	170	23	0	878	58.00
60.00	06000	LABORATORY	193	3,087	912	0	7,921	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	112	62.00
65.00	06500	RESPIRATORY THERAPY	77	1,610	311	0	551	65.00
66.00	06600	PHYSICAL THERAPY	71	1,432	157	0	1,156	66.00
67.00	06700	OCCUPATIONAL THERAPY	23	432	12	0	350	67.00
68.00	06800	SPEECH PATHOLOGY	9	217	0	0	50	68.00
69.00	06900	ELECTROCARDIOLOGY	60	819	22	0	900	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,812	0	152	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	26,704	0	4,919	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	28,525	1,628	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	12	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	21	456	217	0	234	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	41	0	165	0	135	88.00
88.01	08801	RURAL HEALTH CLINIC II	263	0	476	0	689	88.01
91.00	09100	EMERGENCY	212	5,500	908	0	4,026	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,181	35,776	60,414	28,525	52,240	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07955	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	15	0	55	0	0	194.01
194.02	07954	SENIOR CIRCLE	8	0	95	0	0	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,204	35,776	60,564	28,525	52,240	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	568,139	0	568,139	30.00
31.00	03100	INTENSIVE CARE UNIT	109,822	0	109,822	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	414,454	0	414,454	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	10,657	0	10,657	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	102,699	0	102,699	54.00
54.01	03630	ULTRA SOUND	14,086	0	14,086	54.01
56.00	05600	RADIOISOTOPE	10,390	0	10,390	56.00
57.00	05700	CT SCAN	9,761	0	9,761	57.00
58.00	05800	MRI	3,757	0	3,757	58.00
60.00	06000	LABORATORY	85,302	0	85,302	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,247	0	3,247	62.00
65.00	06500	RESPIRATORY THERAPY	34,776	0	34,776	65.00
66.00	06600	PHYSICAL THERAPY	17,594	0	17,594	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,847	0	1,847	67.00
68.00	06800	SPEECH PATHOLOGY	727	0	727	68.00
69.00	06900	ELECTROCARDIOLOGY	3,895	0	3,895	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,229	0	4,229	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,118	0	49,118	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,838	0	37,838	73.00
74.00	07400	RENAL DIALYSIS	177	0	177	74.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03610	SLEEP LAB	2,040	0	2,040	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,326	0	3,326	88.00
88.01	08801	RURAL HEALTH CLINIC II	17,249	0	17,249	88.01
91.00	09100	EMERGENCY	157,945	0	157,945	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,663,075	0	1,663,075	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,939	0	7,939	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,155	0	8,155	192.00
194.00	07955	OTHER NRCC	0	0	0	194.00
194.01	07951	MARKETING	6,757	0	6,757	194.01
194.02	07954	SENIOR CIRCLE	11,562	0	11,562	194.02
194.03	07953	VACANT SPACE	199,257	0	199,257	194.03
194.04	07952	GUEST MEALS	819	0	819	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,897,564	0	1,897,564	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0294

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

Worksheet B-1

Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	125,922					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		125,922				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	805	805	12,471,329			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,450	13,450	1,299,720	-10,654,030	29,630,388	5.00
7.00	00700	OPERATION OF PLANT	24,614	24,614	424,219	0	1,834,342	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	552	552	0	0	92,504	8.00
9.00	00900	HOUSEKEEPING	4,150	4,150	405,624	0	630,259	9.00
10.00	01000	DIETARY	3,878	3,878	0	0	328,844	10.00
11.00	01100	CAFETERIA	0	0	0	0	320,203	11.00
13.00	01300	NURSING ADMINISTRATION	1,284	1,284	899,893	0	1,220,205	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,742	2,742	248,041	0	576,700	14.00
15.00	01500	PHARMACY	1,018	1,018	442,465	0	691,268	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,494	2,494	445	0	154,793	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,732	22,732	942,386	0	1,992,398	30.00
31.00	03100	INTENSIVE CARE UNIT	4,803	4,803	502,702	0	421,200	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,444	15,444	1,990,420	0	6,716,212	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	171	171	4	0	79,529	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,345	4,345	508,943	0	1,140,404	54.00
54.01	03630	ULTRA SOUND	509	509	145,838	0	303,076	54.01
56.00	05600	RADIOISOTOPE	427	427	3,498	0	181,488	56.00
57.00	05700	CT SCAN	0	0	143,810	0	340,982	57.00
58.00	05800	MRI	0	0	36,184	0	383,824	58.00
60.00	06000	LABORATORY	2,987	2,987	655,197	0	1,635,992	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	152	152	0	0	2,291	62.00
65.00	06500	RESPIRATORY THERAPY	1,366	1,366	341,717	0	512,025	65.00
66.00	06600	PHYSICAL THERAPY	551	551	303,948	0	461,231	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	91,724	0	136,772	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	45,965	0	59,003	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	173,726	0	279,695	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	183,851	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,541,841	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,116,591	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	24,000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	96,720	0	147,861	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	222,031	0	402,347	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	1,264,632	0	2,119,827	88.01
91.00	09100	EMERGENCY	6,282	6,282	1,167,179	0	1,978,522	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,756	114,756	12,357,031	-10,654,030	29,010,080	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	385	385	0	0	5,801	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	374	374	0	0	69,693	192.00
194.00	07955	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	205	205	90,909	0	347,502	194.01
194.02	07954	SENIOR CIRCLE	540	540	23,389	0	51,712	194.02
194.03	07953	VACANT SPACE	9,662	9,662	0	0	145,600	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
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)	472,084	1,425,480	2,493,873		10,654,030	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.749019	11.320341	0.199969		0.359564	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,131		203,948	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000973		0.006883	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: 14-0294

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

Worksheet B-1

Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		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	87,053				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	552	130,301			8.00
9.00	00900	HOUSEKEEPING	4,150	0	82,351		9.00
10.00	01000	DIETARY	3,878	0	3,878	47,142	10.00
11.00	01100	CAFETERIA	0	0	0	14,394	11.00
13.00	01300	NURSING ADMINISTRATION	1,284	0	1,284	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,742	0	2,742	0	14.00
15.00	01500	PHARMACY	1,018	0	1,018	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,494	0	2,494	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,732	43,001	22,732	44,032	30.00
31.00	03100	INTENSIVE CARE UNIT	4,803	7,817	4,803	2,638	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	15,444	26,061	15,444	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	171	0	171	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,345	7,817	4,345	0	54.00
54.01	03630	ULTRA SOUND	509	0	509	0	54.01
56.00	05600	RADIOISOTOPE	427	0	427	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	2,987	0	2,987	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	152	0	152	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,366	3,909	1,366	0	65.00
66.00	06600	PHYSICAL THERAPY	551	0	551	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
91.00	09100	EMERGENCY	6,282	41,696	6,282	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,887	130,301	71,185	46,670	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	385	0	385	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	374	0	374	0	192.00
194.00	07955	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	205	0	205	0	194.01
194.02	07954	SENIOR CIRCLE	540	0	540	0	194.02
194.03	07953	VACANT SPACE	9,662	0	9,662	0	194.03
194.04	07952	GUEST MEALS	0	0	0	472	194.04
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)	2,493,905	141,579	975,767	604,131	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.648122	1.086553	11.848879	12.815133	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	383,956	11,390	85,574	81,836	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.410600	0.087413	1.039137	1.735947	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: 14-0294

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

Worksheet B-1

Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
			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					11.00
13.00	01300	NURSING ADMINISTRATION	7,592,422				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,585,360			14.00
15.00	01500	PHARMACY	442,465	28,696	1,116,591		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34	0	264,436,400	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	942,386	100,297	0	5,721,634	30.00
31.00	03100	INTENSIVE CARE UNIT	502,702	15,290	0	238,606	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,990,420	2,269,017	0	64,655,483	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	75,108	0	29,225,472	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	508,943	19,555	0	8,909,187	54.00
54.01	03630	ULTRA SOUND	145,838	11,482	0	2,900,044	54.01
56.00	05600	RADIOISOTOPE	3,498	1,637	0	1,720,965	56.00
57.00	05700	CT SCAN	143,810	33,109	0	31,303,179	57.00
58.00	05800	MRI	36,184	2,153	0	4,432,339	58.00
60.00	06000	LABORATORY	655,197	84,103	0	40,003,632	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	565,413	62.00
65.00	06500	RESPIRATORY THERAPY	341,717	28,702	0	2,782,209	65.00
66.00	06600	PHYSICAL THERAPY	303,948	14,449	0	5,839,457	66.00
67.00	06700	OCCUPATIONAL THERAPY	91,724	1,130	0	1,768,172	67.00
68.00	06800	SPEECH PATHOLOGY	45,965	0	0	254,674	68.00
69.00	06900	ELECTROCARDIOLOGY	173,726	2,034	0	4,545,380	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	259,296	0	766,946	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,462,471	0	24,843,430	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,116,591	8,220,637	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	58,438	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	96,720	20,019	0	1,182,159	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	15,234	0	682,001	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	43,916	0	3,481,229	88.01
91.00	09100	EMERGENCY	1,167,179	83,730	0	20,335,714	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,592,422	5,571,462	1,116,591	264,436,400	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07955	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	0	5,116	0	0	194.01
194.02	07954	SENIOR CIRCLE	0	8,782	0	0	194.02
194.03	07953	VACANT SPACE	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	194.04
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)	1,741,492	913,099	1,097,361	311,486	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.229372	0.163481	0.982778	0.001178	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	35,776	60,564	28,525	52,240	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.004712	0.010843	0.025547	0.000198	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/31/2022 9:40 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,520,643		4,520,643	0	4,520,643	30.00	
31.00	03100	INTENSIVE CARE UNIT	934,710		934,710	0	934,710	31.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,777,107		10,777,107	0	10,777,107	50.00	
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	161,757		161,757	0	161,757	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,893,612		1,893,612	0	1,893,612	54.00	
54.01	03630	ULTRA SOUND	477,185		477,185	0	477,185	54.01	
56.00	05600	RADIOISOTOPE	267,285		267,285	0	267,285	56.00	
57.00	05700	CT SCAN	546,634		546,634	0	546,634	57.00	
58.00	05800	MRI	537,400		537,400	0	537,400	58.00	
60.00	06000	LABORATORY	2,594,436		2,594,436	0	2,594,436	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,937		9,937	0	9,937	62.00	
65.00	06500	RESPIRATORY THERAPY	857,198	0	857,198	0	857,198	65.00	
66.00	06600	PHYSICAL THERAPY	742,348	0	742,348	0	742,348	66.00	
67.00	06700	OCCUPATIONAL THERAPY	213,703	0	213,703	0	213,703	67.00	
68.00	06800	SPEECH PATHOLOGY	92,876	0	92,876	0	92,876	68.00	
69.00	06900	ELECTROCARDIOLOGY	437,744		437,744	0	437,744	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	293,250		293,250	0	293,250	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,887,627		3,887,627	0	3,887,627	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,625,122		2,625,122	0	2,625,122	73.00	
74.00	07400	RENAL DIALYSIS	32,699		32,699	0	32,699	74.00	
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00	
76.01	03610	SLEEP LAB	232,111		232,111	0	232,111	76.01	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	558,414		558,414	0	558,414	88.00	
88.01	08801	RURAL HEALTH CLINIC II	2,945,340		2,945,340	0	2,945,340	88.01	
91.00	09100	EMERGENCY	3,336,915		3,336,915	0	3,336,915	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	806,594		806,594		806,594	92.00	
200.00		Subtotal (see instructions)	39,782,647	0	39,782,647	0	39,782,647	200.00	
201.00		Less Observation Beds	806,594		806,594		806,594	201.00	
202.00		Total (see instructions)	38,976,053	0	38,976,053	0	38,976,053	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/31/2022 9:40 am

			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,735,669		4,735,669			30.00
31.00	03100	INTENSIVE CARE UNIT	238,606		238,606			31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,668,781	51,986,702	64,655,483	0.166685	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	5,584,722	23,640,750	29,225,472	0.005535	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	859,547	8,049,640	8,909,187	0.212546	0.000000	54.00
54.01	03630	ULTRA SOUND	142,510	2,757,534	2,900,044	0.164544	0.000000	54.01
56.00	05600	RADIOISOTOPE	142,642	1,578,323	1,720,965	0.155311	0.000000	56.00
57.00	05700	CT SCAN	4,071,945	27,231,234	31,303,179	0.017463	0.000000	57.00
58.00	05800	MRI	527,558	3,904,781	4,432,339	0.121245	0.000000	58.00
60.00	06000	LABORATORY	5,392,978	34,610,654	40,003,632	0.064855	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	369,306	196,107	565,413	0.017575	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,377,148	1,405,061	2,782,209	0.308100	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	851,475	4,987,982	5,839,457	0.127126	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	446,252	1,321,920	1,768,172	0.120861	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	20,553	234,121	254,674	0.364686	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	707,543	3,837,837	4,545,380	0.096305	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	712,088	54,858	766,946	0.382361	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,857,633	15,985,797	24,843,430	0.156485	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,861,728	5,358,909	8,220,637	0.319333	0.000000	73.00
74.00	07400	RENAL DIALYSIS	58,438	0	58,438	0.559550	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	3,115	1,179,044	1,182,159	0.196345	0.000000	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	682,001	682,001			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,481,229	3,481,229			88.01
91.00	09100	EMERGENCY	1,833,694	18,502,020	20,335,714	0.164091	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	306,933	679,032	985,965	0.818076	0.000000	92.00
200.00		Subtotal (see instructions)	52,770,864	211,665,536	264,436,400			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	52,770,864	211,665,536	264,436,400			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.166685			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
53.00	05300 ANESTHESIOLOGY	0.005535			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.212546			54.00
54.01	03630 ULTRA SOUND	0.164544			54.01
56.00	05600 RADIOISOTOPE	0.155311			56.00
57.00	05700 CT SCAN	0.017463			57.00
58.00	05800 MRI	0.121245			58.00
60.00	06000 LABORATORY	0.064855			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.017575			62.00
65.00	06500 RESPIRATORY THERAPY	0.308100			65.00
66.00	06600 PHYSICAL THERAPY	0.127126			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.120861			67.00
68.00	06800 SPEECH PATHOLOGY	0.364686			68.00
69.00	06900 ELECTROCARDIOLOGY	0.096305			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.382361			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.156485			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.319333			73.00
74.00	07400 RENAL DIALYSIS	0.559550			74.00
76.00	03020 ACUPUNCTURE	0.000000			76.00
76.01	03610 SLEEP LAB	0.196345			76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
88.01	08801 RURAL HEALTH CLINIC II				88.01
91.00	09100 EMERGENCY	0.164091			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.818076			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/31/2022 9:40 am

				Title XIX	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,520,643		4,520,643	0	0
31.00	03100	INTENSIVE CARE UNIT	934,710		934,710	0	0
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,777,107		10,777,107	0	0
51.00	05100	RECOVERY ROOM	0		0	0	0
53.00	05300	ANESTHESIOLOGY	161,757		161,757	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,893,612		1,893,612	0	0
54.01	03630	ULTRA SOUND	477,185		477,185	0	0
56.00	05600	RADIOISOTOPE	267,285		267,285	0	0
57.00	05700	CT SCAN	546,634		546,634	0	0
58.00	05800	MRI	537,400		537,400	0	0
60.00	06000	LABORATORY	2,594,436		2,594,436	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,937		9,937	0	0
65.00	06500	RESPIRATORY THERAPY	857,198	0	857,198	0	0
66.00	06600	PHYSICAL THERAPY	742,348	0	742,348	0	0
67.00	06700	OCCUPATIONAL THERAPY	213,703	0	213,703	0	0
68.00	06800	SPEECH PATHOLOGY	92,876	0	92,876	0	0
69.00	06900	ELECTROCARDIOLOGY	437,744		437,744	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	293,250		293,250	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,887,627		3,887,627	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,625,122		2,625,122	0	0
74.00	07400	RENAL DIALYSIS	32,699		32,699	0	0
76.00	03020	ACUPUNCTURE	0		0	0	0
76.01	03610	SLEEP LAB	232,111		232,111	0	0
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	558,414		558,414	0	0
88.01	08801	RURAL HEALTH CLINIC II	2,945,340		2,945,340	0	0
91.00	09100	EMERGENCY	3,336,915		3,336,915	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	806,594		806,594		0
200.00		Subtotal (see instructions)	39,782,647	0	39,782,647	0	0
201.00		Less Observation Beds	806,594		806,594		0
202.00		Total (see instructions)	38,976,053	0	38,976,053	0	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/31/2022 9:40 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,735,669		4,735,669		30.00
31.00	03100	INTENSIVE CARE UNIT	238,606		238,606		31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,668,781	51,986,702	64,655,483	0.166685	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000
53.00	05300	ANESTHESIOLOGY	5,584,722	23,640,750	29,225,472	0.005535	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	859,547	8,049,640	8,909,187	0.212546	0.000000
54.01	03630	ULTRA SOUND	142,510	2,757,534	2,900,044	0.164544	0.000000
56.00	05600	RADIOISOTOPE	142,642	1,578,323	1,720,965	0.155311	0.000000
57.00	05700	CT SCAN	4,071,945	27,231,234	31,303,179	0.017463	0.000000
58.00	05800	MRI	527,558	3,904,781	4,432,339	0.121245	0.000000
60.00	06000	LABORATORY	5,392,978	34,610,654	40,003,632	0.064855	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	369,306	196,107	565,413	0.017575	0.000000
65.00	06500	RESPIRATORY THERAPY	1,377,148	1,405,061	2,782,209	0.308100	0.000000
66.00	06600	PHYSICAL THERAPY	851,475	4,987,982	5,839,457	0.127126	0.000000
67.00	06700	OCCUPATIONAL THERAPY	446,252	1,321,920	1,768,172	0.120861	0.000000
68.00	06800	SPEECH PATHOLOGY	20,553	234,121	254,674	0.364686	0.000000
69.00	06900	ELECTROCARDIOLOGY	707,543	3,837,837	4,545,380	0.096305	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	712,088	54,858	766,946	0.382361	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,857,633	15,985,797	24,843,430	0.156485	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	2,861,728	5,358,909	8,220,637	0.319333	0.000000
74.00	07400	RENAL DIALYSIS	41,457	16,981	58,438	0.559550	0.000000
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000
76.01	03610	SLEEP LAB	3,115	1,179,044	1,182,159	0.196345	0.000000
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	682,001	682,001	0.818788	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	3,481,229	3,481,229	0.846063	0.000000
91.00	09100	EMERGENCY	1,833,694	18,502,020	20,335,714	0.164091	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	306,933	679,032	985,965	0.818076	0.000000
200.00		Subtotal (see instructions)	52,753,883	211,682,517	264,436,400		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	52,753,883	211,682,517	264,436,400		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630	ULTRA SOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
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
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
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: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
5/31/2022 9:40 am

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		568,139	0	568,139	2,438	233.03	30.00
31.00	INTENSIVE CARE UNIT		109,822		109,822	120	915.18	31.00
200.00	Total (lines 30 through 199)		677,961		677,961	2,558		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		1,063	247,711				
31.00	INTENSIVE CARE UNIT		35	32,031				
200.00	Total (lines 30 through 199)		1,098	279,742	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description			Title XVIII		Hospital	PPS		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	414,454	64,655,483	0.006410	4,991,479	31,995	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	10,657	29,225,472	0.000365	2,232,879	815	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	102,699	8,909,187	0.011527	492,486	5,677	54.00
54.01	03630	ULTRA SOUND	14,086	2,900,044	0.004857	64,748	314	54.01
56.00	05600	RADIOISOTOPE	10,390	1,720,965	0.006037	63,878	386	56.00
57.00	05700	CT SCAN	9,761	31,303,179	0.000312	1,886,011	588	57.00
58.00	05800	MRI	3,757	4,432,339	0.000848	5,898	5	58.00
60.00	06000	LABORATORY	85,302	40,003,632	0.002132	2,678,467	5,710	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,247	565,413	0.005743	176,611	1,014	62.00
65.00	06500	RESPIRATORY THERAPY	34,776	2,782,209	0.012499	745,567	9,319	65.00
66.00	06600	PHYSICAL THERAPY	17,594	5,839,457	0.003013	520,011	1,567	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,847	1,768,172	0.001045	280,434	293	67.00
68.00	06800	SPEECH PATHOLOGY	727	254,674	0.002855	15,429	44	68.00
69.00	06900	ELECTROCARDIOLOGY	3,895	4,545,380	0.000857	439,584	377	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,229	766,946	0.005514	419,840	2,315	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,118	24,843,430	0.001977	4,775,901	9,442	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,838	8,220,637	0.004603	1,256,028	5,781	73.00
74.00	07400	RENAL DIALYSIS	177	58,438	0.003029	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	2,040	1,182,159	0.001726	391	1	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,326	682,001	0.004877	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	17,249	3,481,229	0.004955	0	0	88.01
91.00	09100	EMERGENCY	157,945	20,335,714	0.007767	921,467	7,157	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	101,370	985,965	0.102813	141,410	14,539	92.00
200.00		Total (lines 50 through 199)	1,086,484	259,462,125		22,108,519	97,339	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0294		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 5/31/2022 9:40 am		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	2,438	0.00	1,063		30.00	
31.00	03100	INTENSIVE CARE UNIT			0	120	0.00	35		31.00	
200.00		Total (lines 30 through 199)			0	2,558		1,098		200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0						30.00	
31.00	03100	INTENSIVE CARE UNIT		0						31.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description			Title XVIII		Hospital		PPS
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0294		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/31/2022 9:40 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	64,655,483	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	29,225,472	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	8,909,187	0.000000	54.00
54.01	03630	ULTRA SOUND		0	0	0	2,900,044	0.000000	54.01
56.00	05600	RADIOISOTOPE		0	0	0	1,720,965	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	31,303,179	0.000000	57.00
58.00	05800	MRI		0	0	0	4,432,339	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	40,003,632	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	565,413	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	2,782,209	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	5,839,457	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	1,768,172	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	254,674	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	4,545,380	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	766,946	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	24,843,430	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	8,220,637	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	58,438	0.000000	74.00
76.00	03020	ACUPUNCTURE		0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB		0	0	0	1,182,159	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	682,001	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	3,481,229	0.000000	88.01
91.00	09100	EMERGENCY		0	0	0	20,335,714	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	985,965	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	259,462,125		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0294		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/31/2022 9:40 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	4,991,479	0	13,908,261	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0.000000	2,232,879	0	5,964,881	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	492,486	0	2,431,649	0	54.00
54.01	03630	ULTRA SOUND		0.000000	64,748	0	838,147	0	54.01
56.00	05600	RADIOISOTOPE		0.000000	63,878	0	611,418	0	56.00
57.00	05700	CT SCAN		0.000000	1,886,011	0	8,509,468	0	57.00
58.00	05800	MRI		0.000000	5,898	0	1,220,626	0	58.00
60.00	06000	LABORATORY		0.000000	2,678,467	0	3,608,272	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0.000000	176,611	0	99,009	0	62.00
65.00	06500	RESPIRATORY THERAPY		0.000000	745,567	0	615,189	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	520,011	0	64,430	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	280,434	0	39,067	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	15,429	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	439,584	0	1,389,202	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	419,840	0	32,800	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	4,775,901	0	5,717,846	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	1,256,028	0	1,401,072	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE		0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB		0.000000	391	0	337,822	0	76.01
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
91.00	09100	EMERGENCY		0.000000	921,467	0	4,279,496	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	141,410	0	251,652	0	92.00
200.00		Total (lines 50 through 199)			22,108,519	0	51,320,307	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/31/2022 9:40 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.166685	13,908,261	0	0	2,318,298	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.005535	5,964,881	0	0	33,016	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.212546	2,431,649	0	0	516,837	54.00
54.01	03630	ULTRA SOUND	0.164544	838,147	0	0	137,912	54.01
56.00	05600	RADIOISOTOPE	0.155311	611,418	0	0	94,960	56.00
57.00	05700	CT SCAN	0.017463	8,509,468	0	0	148,601	57.00
58.00	05800	MRI	0.121245	1,220,626	0	0	147,995	58.00
60.00	06000	LABORATORY	0.064855	3,608,272	0	0	234,014	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.017575	99,009	0	0	1,740	62.00
65.00	06500	RESPIRATORY THERAPY	0.308100	615,189	0	0	189,540	65.00
66.00	06600	PHYSICAL THERAPY	0.127126	64,430	0	0	8,191	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.120861	39,067	0	0	4,722	67.00
68.00	06800	SPEECH PATHOLOGY	0.364686	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.096305	1,389,202	0	0	133,787	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.382361	32,800	0	0	12,541	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.156485	5,717,846	0	0	894,757	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.319333	1,401,072	1,128	0	447,409	73.00
74.00	07400	RENAL DIALYSIS	0.559550	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.196345	337,822	0	0	66,330	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
91.00	09100	EMERGENCY	0.164091	4,279,496	0	0	702,227	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.818076	251,652	0	0	205,870	92.00
200.00		Subtotal (see instructions)		51,320,307	1,128	0	6,298,747	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		51,320,307	1,128	0	6,298,747	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0294		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/31/2022 9:40 am
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
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 PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	360	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
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)	360	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	360	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
5/31/2022 9:40 am

			Title XIX		Hospital	Cost	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	568,139	0	568,139	2,438	233.03	30.00
31.00	INTENSIVE CARE UNIT	109,822		109,822	120	915.18	31.00
200.00	Total (lines 30 through 199)	677,961		677,961	2,558		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	47	10,952				
31.00	INTENSIVE CARE UNIT	0	0				
200.00	Total (lines 30 through 199)	47	10,952				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description			Title XIX		Hospital	Cost		
			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	414,454	64,655,483	0.006410	290,808	1,864	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	10,657	29,225,472	0.000365	133,286	49	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	102,699	8,909,187	0.011527	17,180	198	54.00
54.01	03630	ULTRA SOUND	14,086	2,900,044	0.004857		0	54.01
56.00	05600	RADIOISOTOPE	10,390	1,720,965	0.006037	0	0	56.00
57.00	05700	CT SCAN	9,761	31,303,179	0.000312	44,350	14	57.00
58.00	05800	MRI	3,757	4,432,339	0.000848	5,898	5	58.00
60.00	06000	LABORATORY	85,302	40,003,632	0.002132	85,455	182	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,247	565,413	0.005743	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	34,776	2,782,209	0.012499	50,821	635	65.00
66.00	06600	PHYSICAL THERAPY	17,594	5,839,457	0.003013	22,248	67	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,847	1,768,172	0.001045	5,371	6	67.00
68.00	06800	SPEECH PATHOLOGY	727	254,674	0.002855	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,895	4,545,380	0.000857	483	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,229	766,946	0.005514	139,583	770	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,118	24,843,430	0.001977	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,838	8,220,637	0.004603	62,001	285	73.00
74.00	07400	RENAL DIALYSIS	177	58,438	0.003029	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	2,040	1,182,159	0.001726	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,326	682,001	0.004877	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	17,249	3,481,229	0.004955	0	0	88.01
91.00	09100	EMERGENCY	157,945	20,335,714	0.007767	16,771	130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	101,370	985,965	0.102813	1,930	198	92.00
200.00		Total (lines 50 through 199)	1,086,484	259,462,125		876,185	4,403	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0294		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 5/31/2022 9:40 am		
					Title XIX		Hospital		Cost		
Cost Center Description					Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	2,438	0.00		47	30.00	
31.00	03100	INTENSIVE CARE UNIT			0	120	0.00		0	31.00	
200.00		Total (lines 30 through 199)			0	2,558			47	200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0						30.00	
31.00	03100	INTENSIVE CARE UNIT		0						31.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description			Title XIX		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
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	03630	ULTRA SOUND	0	0	0	0	0 54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0 62.00
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 PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0 76.00
76.01	03610	SLEEP LAB	0	0	0	0	0 76.01
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
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: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description			Title XIX		Hospital	Cost	
			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	64,655,483	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	29,225,472	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,909,187	0.000000
54.01	03630	ULTRA SOUND	0	0	0	2,900,044	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	1,720,965	0.000000
57.00	05700	CT SCAN	0	0	0	31,303,179	0.000000
58.00	05800	MRI	0	0	0	4,432,339	0.000000
60.00	06000	LABORATORY	0	0	0	40,003,632	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	565,413	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,782,209	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	5,839,457	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,768,172	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	254,674	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,545,380	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	766,946	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	24,843,430	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,220,637	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	58,438	0.000000
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000
76.01	03610	SLEEP LAB	0	0	0	1,182,159	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	682,001	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	3,481,229	0.000000
91.00	09100	EMERGENCY	0	0	0	20,335,714	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	985,965	0.000000
200.00		Total (lines 50 through 199)	0	0	0	259,462,125	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description		Title XIX		Hospital		Cost	
		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	290,808	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	133,286	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	17,180	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	44,350	0	0	57.00
58.00	05800	MRI	0.000000	5,898	0	0	58.00
60.00	06000	LABORATORY	0.000000	85,455	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	50,821	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	22,248	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	5,371	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	483	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	139,583	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	62,001	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	88.01
91.00	09100	EMERGENCY	0.000000	16,771	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,930	0	0	92.00
200.00		Total (lines 50 through 199)		876,185	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0294

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

Worksheet D-1

Date/Time Prepared:
5/31/2022 9:40 am

Title XVIII		Hospital	PPS
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,438	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,438	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,003	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)	1,063	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)	4,520,643	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)	4,520,643	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)	4,520,643	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)	1,854.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,971,057	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)	1,971,057	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0294

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

Worksheet D-1

Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description		Title XVIII		Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	934,710	120	7,789.25	35	272,624
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
	Cost Center Description					
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,133,695
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,377,376
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					279,742
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					97,339
52.00	Total Program excludable cost (sum of lines 50 and 51)					377,081
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,000,295
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
	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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
	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)					435
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,854.24
89.00	Observation bed cost (line 87 x line 88) (see instructions)					806,594

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0294

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

Worksheet D-1

Date/Time Prepared:
5/31/2022 9:40 am

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	568,139	4,520,643	0.125677	806,594	101,370	90.00
91.00 Nursing Program cost	0	4,520,643	0.000000	806,594	0	91.00
92.00 Allied health cost	0	4,520,643	0.000000	806,594	0	92.00
93.00 All other Medical Education	0	4,520,643	0.000000	806,594	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0294

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

Worksheet D-1

Date/Time Prepared:
5/31/2022 9:40 am

Title XIX		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,438	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,438	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,003	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)	47	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)	4,520,643	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)	4,520,643	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)	4,520,643	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)	1,854.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	87,149	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)	87,149	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0294

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

Worksheet D-1

Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital 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	934,710	120	7,789.25	0	0	43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description								
							1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						156,577	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						243,726	49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						435	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,854.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						806,594	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0294

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

Worksheet D-1

Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description		Title XIX		Hospital		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	568,139	4,520,643	0.125677	806,594	101,370	90.00
91.00	Nursing Program cost	0	4,520,643	0.000000	806,594	0	91.00
92.00	Allied health cost	0	4,520,643	0.000000	806,594	0	92.00
93.00	All other Medical Education	0	4,520,643	0.000000	806,594	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0294	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/31/2022 9:40 am
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		2,364,887	30.00
31.00	03100	INTENSIVE CARE UNIT		132,037	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.166685	4,991,479	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0.005535	2,232,879	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.212546	492,486	54.00
54.01	03630	ULTRA SOUND	0.164544	64,748	54.01
56.00	05600	RADIOISOTOPE	0.155311	63,878	56.00
57.00	05700	CT SCAN	0.017463	1,886,011	57.00
58.00	05800	MRI	0.121245	5,898	58.00
60.00	06000	LABORATORY	0.064855	2,678,467	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.017575	176,611	62.00
65.00	06500	RESPIRATORY THERAPY	0.308100	745,567	65.00
66.00	06600	PHYSICAL THERAPY	0.127126	520,011	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.120861	280,434	67.00
68.00	06800	SPEECH PATHOLOGY	0.364686	15,429	68.00
69.00	06900	ELECTROCARDIOLOGY	0.096305	439,584	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.382361	419,840	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.156485	4,775,901	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.319333	1,256,028	73.00
74.00	07400	RENAL DIALYSIS	0.559550	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	76.00
76.01	03610	SLEEP LAB	0.196345	391	76.01
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
91.00	09100	EMERGENCY	0.164091	921,467	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.818076	141,410	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		22,108,519	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)		22,108,519	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0294	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/31/2022 9:40 am
Cost Center Description			Title XIX	Hospital	Cost
			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		119,682	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.166685	290,808	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0.005535	133,286	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.212546	17,180	54.00
54.01	03630	ULTRA SOUND	0.164544	0	54.01
56.00	05600	RADIOISOTOPE	0.155311	0	56.00
57.00	05700	CT SCAN	0.017463	44,350	57.00
58.00	05800	MRI	0.121245	5,898	58.00
60.00	06000	LABORATORY	0.064855	85,455	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.017575	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.308100	50,821	65.00
66.00	06600	PHYSICAL THERAPY	0.127126	22,248	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.120861	5,371	67.00
68.00	06800	SPEECH PATHOLOGY	0.364686	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.096305	483	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.382361	139,583	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.156485	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.319333	62,001	73.00
74.00	07400	RENAL DIALYSIS	0.559550	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	76.00
76.01	03610	SLEEP LAB	0.196345	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.818788	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.846063	0	88.01
91.00	09100	EMERGENCY	0.164091	16,771	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.818076	1,930	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		876,185	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)		876,185	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0294	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/31/2022 9:40 am
		Title XVIII	Hospital	PPS
		1.00		
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,179,496		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	786,351		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)	291,048		2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	7,660		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)		45.81	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)		6.34	30.00
31.00	Percentage of Medicaid patient days (see instructions)		12.06	31.00
32.00	Sum of lines 30 and 31		18.40	32.00
33.00	Allowable disproportionate share percentage (see instructions)		4.71	33.00
34.00	Disproportionate share adjustment (see instructions)		34,923	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0294	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/31/2022 9:40 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	174,222	162,651		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	130,308	40,997		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	171,305			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		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 (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			45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)	3,470,783			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	4,343,968			48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)		4,125,672		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		287,950		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		37,885		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)		4,451,507		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		4,451,507		61.00
62.00	Deductibles billed to program beneficiaries		410,992		62.00
63.00	Coinsurance billed to program beneficiaries		0		63.00
64.00	Allowable bad debts (see instructions)		144,248		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		93,761		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		99,180		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		4,134,276		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)		626		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-3,162		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		2,785		70.93
70.94	HRR adjustment amount (see instructions)		-14,607		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0294	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/31/2022 9:40 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	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)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		45,749	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,074,169	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		4,251,187	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)		-177,018	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		550,076	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)		489,821	165,068
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		1.0012776903	1.0000000000
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		626	0
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.9956	0.9939
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-2,155	-1,007
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.			
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			
202.00	Medicare discharges (see instructions)			
203.00	Case-mix adjustment factor (see instructions)			
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			
205.00	Case-mix adjusted target amount (line 203 times line 204)			
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			
209.00	Adjustment to Medicare IPPS payments (see instructions)			
210.00	Reserved for future use			
211.00	Total adjustment to Medicare IPPS payments (see instructions)			
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			
213.00	Low-volume adjustment (see instructions)			
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0294	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/31/2022 9:40 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		360	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,298,747	2.00
3.00	OPPS payments		4,219,318	3.00
4.00	Outlier payment (see instructions)		22,820	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)		360	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,128	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)		1,128	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)		1,128	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		768	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)		360	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)		4,242,138	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		110	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		745,721	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)		3,496,667	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)		3,496,667	30.00
31.00	Primary payer payments		137	31.00
32.00	Subtotal (line 30 minus line 31)		3,496,530	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)		188,675	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		122,639	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		154,229	36.00
37.00	Subtotal (see instructions)		3,619,169	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)		3,619,169	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		3,611,609	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)		7,560	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: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part I
Date/Time Prepared:
5/31/2022 9:40 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,118,204		3,496,195	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		103,583		115,414	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	12/01/2021	29,400		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)		29,400		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)		4,251,187		3,611,609	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		7,560	6.01
6.02	SETTLEMENT TO PROGRAM		177,018		0	6.02
7.00	Total Medicare program liability (see instructions)		4,074,169		3,619,169	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: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part II
Date/Time Prepared:
5/31/2022 9:40 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet E-3
Part VII
Date/Time Prepared:
5/31/2022 9:40 am

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		243,726		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		243,726	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		243,726	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		876,185	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		876,185	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		876,185	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		632,459	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		243,726	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		243,726	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		243,726	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		243,726	0	36.00
37.00	NO SETTLEMENT		-243,726	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 14-0294

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

Worksheet G

Date/Time Prepared:
5/31/2022 9:40 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-519,355	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	7,916,031	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,740,755	0	0	0	6.00
7.00	Inventory	1,767,668	0	0	0	7.00
8.00	Prepaid expenses	501,346	0	0	0	8.00
9.00	Other current assets	69,779	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)	5,994,714	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,640,000	0	0	0	12.00
13.00	Land improvements	162,111	0	0	0	13.00
14.00	Accumulated depreciation	-20,843	0	0	0	14.00
15.00	Buildings	6,697,204	0	0	0	15.00
16.00	Accumulated depreciation	-286,916	0	0	0	16.00
17.00	Leasehold improvements	88,138	0	0	0	17.00
18.00	Accumulated depreciation	-22,280	0	0	0	18.00
19.00	Fixed equipment	188,119	0	0	0	19.00
20.00	Accumulated depreciation	-79,129	0	0	0	20.00
21.00	Automobiles and trucks	3,255	0	0	0	21.00
22.00	Accumulated depreciation	-2,441	0	0	0	22.00
23.00	Major movable equipment	3,326,062	0	0	0	23.00
24.00	Accumulated depreciation	-964,399	0	0	0	24.00
25.00	Minor equipment depreciable	1,576,598	0	0	0	25.00
26.00	Accumulated depreciation	-387,397	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,918,082	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,938,541	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,938,541	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	20,851,337	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	5,534,229	0	0	0	37.00
38.00	Salaries, wages, and fees payable	973,076	0	0	0	38.00
39.00	Payroll taxes payable	234,851	0	0	0	39.00
40.00	Notes and loans payable (short term)	647,652	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	6,393,876	0	0	0	43.00
44.00	Other current liabilities	846,110	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,629,794	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	405,336	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	18,333	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	423,669	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,053,463	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	5,797,874				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)	5,797,874	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	20,851,337	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0294

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

Worksheet G-1

Date/Time Prepared:
5/31/2022 9:40 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		654,699		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,497,330				2.00
3.00	Total (sum of line 1 and line 2)		5,152,029		0		3.00
4.00	RECONCILE TO GENERAL LEDGER	645,845		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)		645,845		0		10.00
11.00	Subtotal (line 3 plus line 10)		5,797,874		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)		5,797,874		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	RECONCILE TO GENERAL LEDGER		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: 14-0294

Period:
From 01/01/2021
To 12/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
5/31/2022 9:40 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,735,669		4,735,669	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				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)	4,735,669		4,735,669	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	238,606		238,606	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)	238,606		238,606	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,974,275		4,974,275	17.00
18.00	Ancillary services	47,779,608	189,017,267	236,796,875	18.00
19.00	Outpatient services	0	18,502,020	18,502,020	19.00
20.00	RURAL HEALTH CLINIC	0	682,001	682,001	20.00
20.01	RURAL HEALTH CLINIC II	0	3,481,229	3,481,229	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	52,753,883	211,682,517	264,436,400	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		48,877,353		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		48,877,353		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0294

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

Worksheet G-3

Date/Time Prepared:
5/31/2022 9:40 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	264,436,400	1.00
2.00	Less contractual allowances and discounts on patients' accounts	211,742,328	2.00
3.00	Net patient revenues (line 1 minus line 2)	52,694,072	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	48,877,353	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,816,719	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	1,010	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	53,093	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	239,584	22.00
23.00	Governmental appropriations	84,177	23.00
24.00	OTHER MISC INCOME	198,114	24.00
24.50	COVID-19 PHE Funding	104,633	24.50
25.00	Total other income (sum of lines 6-24)	680,611	25.00
26.00	Total (line 5 plus line 25)	4,497,330	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,497,330	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0294	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 5/31/2022 9:40 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		222,210	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		65,740	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)		5.82	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)		287,950	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: 14-0294

Period:

Worksheet M-1

Component CCN: 14-8523

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/31/2022 9:40 am

		RHC I		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	0	0	0	0	0
2.00	Physician Assistant	136,770	0	136,770	-6,990	129,780
3.00	Nurse Practitioner	0	0	0	0	0
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	85,261	0	85,261	0	85,261
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	222,031	0	222,031	-6,990	215,041
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	15,906	15,906	0	15,906
16.00	Transportation (Health Care Staff)	0	73	73	0	73
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	1,074	1,074	0	1,074
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	17,053	17,053	0	17,053
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	222,031	17,053	239,084	-6,990	232,094
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	6,990	6,990
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	6,990	6,990
FACILITY OVERHEAD						
29.00	Facility Costs	0	39,184	39,184	0	39,184
30.00	Administrative Costs	0	127,729	127,729	-48,049	79,680
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	166,913	166,913	-48,049	118,864
32.00	Total facility costs (sum of lines 22, 28 and 31)	222,031	183,966	405,997	-48,049	357,948

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294

Period:

Worksheet M-1

Component CCN: 14-8523

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/31/2022 9:40 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	129,780	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	85,261	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	215,041	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	15,906	15.00
16.00	Transportation (Health Care Staff)	0	73	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	1,074	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	17,053	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	232,094	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	6,990	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	6,990	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	39,184	29.00
30.00	Administrative Costs	0	79,680	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	118,864	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	357,948	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294

Period:

Worksheet M-1

Component CCN: 14-8605

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/31/2022 9:40 am

		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	232,801	0	232,801	0	232,801
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	571,059	0	571,059	-19,851	551,208
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	199,211	0	199,211	0	199,211
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	261,561	0	261,561	0	261,561
10.00	Subtotal (sum of lines 1 through 9)	1,264,632	0	1,264,632	-19,851	1,244,781
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	38,967	38,967	0	38,967
16.00	Transportation (Health Care Staff)	0	2,335	2,335	0	2,335
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	114	114	0	114
19.00	Other Health Care Costs	0	39,116	39,116	0	39,116
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	80,532	80,532	0	80,532
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,264,632	80,532	1,345,164	-19,851	1,325,313
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	19,851	19,851
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	19,851	19,851
FACILITY OVERHEAD						
29.00	Facility Costs	0	17,046	17,046	0	17,046
30.00	Administrative Costs	0	770,182	770,182	-265,452	504,730
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	787,228	787,228	-265,452	521,776
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,264,632	867,760	2,132,392	-265,452	1,866,940

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294

Period:

Worksheet M-1

Component CCN: 14-8605

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/31/2022 9:40 am

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	232,801	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	551,208	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	199,211	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	261,561	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,244,781	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	38,967	15.00
16.00	Transportation (Health Care Staff)	0	2,335	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	114	18.00
19.00	Other Health Care Costs	0	39,116	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	80,532	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,325,313	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	19,851	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	19,851	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	17,046	29.00
30.00	Administrative Costs	0	504,730	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	521,776	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,866,940	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0294

Period:

Worksheet M-2

Component CCN: 14-8523

From 01/01/2021
To 12/31/2021

Date/Time Prepared:

5/31/2022 9:40 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.90	3,121	2,100	1,890		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.90	3,121		1,890	3,121	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.90	3,121			3,121	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)					232,094	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					6,990	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					239,084	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.970763	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					118,864	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					200,466	15.00
16.00	Total overhead (sum of lines 14 and 15)					319,330	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					319,330	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					309,994	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					542,088	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0294

Period:

Worksheet M-2

Component CCN: 14-8605

From 01/01/2021
To 12/31/2021

Date/Time Prepared:

5/31/2022 9:40 am

		RHC II		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.00	3,037	4,200	4,200	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	4.33	11,381	2,100	9,093	3.00
4.00	Subtotal (sum of lines 1 through 3)	5.33	14,418		13,293	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)	5.33	14,418		14,418	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)				1,325,313	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				19,851	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,345,164	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.985243	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				521,776	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,078,400	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,600,176	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,600,176	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,576,562	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				2,901,875	20.00

Health Financial Systems		CROSSROADS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0294	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3	
		Component CCN: 14-8523		Date/Time Prepared: 5/31/2022 9:40 am	
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			542,088	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			27,820	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			514,268	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,121	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)			3,121	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			164.78	7.00
			Calculation of Limit (1)		
			Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		87.52	131.30	8.00
9.00	Rate for Program covered visits (see instructions)		164.78	131.30	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		323	1,380	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		53,224	181,194	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	234,418	16.00
16.01	Total program charges (see instructions)(from contractor's records)			301,258	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			36,024	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			28,031	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.)			139,413	16.04
16.05	Total program cost (see instructions)		0	167,444	16.05
17.00	Primary payer amounts			322	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			32,121	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			46,623	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			167,122	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			17,643	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			184,765	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	SEQUESTRATION			29	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)			184,794	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			152,117	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)			32,677	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: 14-0294 Component CCN: 14-8605	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/31/2022 9:40 am	
			Title XVIII	RHC II	Cost
					1.00
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,901,875	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			16,542	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,885,333	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			14,418	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)			14,418	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			200.12	7.00
			Calculation of Limit (1)		
			Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		87.52	285.63	8.00
9.00	Rate for Program covered visits (see instructions)		200.12	200.12	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		906	3,316	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		181,309	663,598	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	844,907	16.00
16.01	Total program charges (see instructions)(from contractor's records)			818,672	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			103,029	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			106,331	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.)			522,650	16.04
16.05	Total program cost (see instructions)		0	628,981	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			85,264	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			126,076	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			628,981	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			10,500	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			639,481	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)			639,481	26.00
26.01	Sequestration adjustment (see instructions)			0	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			1,097,914	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)			-458,433	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: 14-0294

Period:

Worksheet M-4

Component CCN: 14-8523

From 01/01/2021

Date/Time Prepared:

To 12/31/2021

5/31/2022 9:40 am

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	215,041	215,041	215,041	215,041	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000000	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	0	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2,847	9,064	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,847	9,064	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	232,094	232,094	232,094	232,094	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	309,994	309,994	309,994	309,994	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.012267	0.039053	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,803	12,106	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6,650	21,170	0	0	10.00
11.00	Total number of injections/infusions (from your records)	27	275	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	246.30	76.98	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	21	162	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)	5,172	12,471	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)		27,820			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)		17,643			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0294

Period:

Worksheet M-4

Component CCN: 14-8605

From 01/01/2021

Date/Time Prepared:

To 12/31/2021

5/31/2022 9:40 am

		Title XVIII		RHC II	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,244,781	1,244,781	1,244,781	1,244,781	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000000	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	0	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	4,640	2,915	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4,640	2,915	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,325,313	1,325,313	1,325,313	1,325,313	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,576,562	1,576,562	1,576,562	1,576,562	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.003501	0.002199	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	5,520	3,467	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	10,160	6,382	0	0	10.00
11.00	Total number of injections/infusions (from your records)	44	190	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	230.91	33.59	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	35	72	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)	8,082	2,418	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)		16,542			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)		10,500			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0294 Component CCN: 14-8523	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/31/2022 9:40 am
		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		109,817	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		12/01/2021	42,300	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		42,300	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		152,117	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		32,677	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		184,794	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: 14-0294 Component CCN: 14-8605	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/31/2022 9:40 am
		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,097,914	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)		1,097,914	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)		0	6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		458,433	6.02
7.00	Total Medicare program liability (see instructions)		639,481	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00