

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: 14-1300	Period: From 09/01/2020 To 08/31/2021	Worksheet S Parts I-III Date/Time Prepared: 1/31/2022 10:41 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 1/31/2022	Time: 10:41 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 THOMAS H BOYD CRITICAL ACC HOSPITAL (14-1300) for the cost reporting period beginning 09/01/2020 and ending 08/31/2021 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	Deborah Campbell	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	Deborah Campbell		2
3	Signatory Title	CHIEF EXECUTIVE OFFICER		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	32,228	84,824	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	17,651	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		126,327		0	10.00
200.00 Total	0	49,879	211,151	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: 14-1300		Period: From 09/01/2020 To 08/31/2021		Worksheet S-2 Part I Date/Time Prepared: 1/31/2022 10:41 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 800 SCHOOL STREET			PO Box:				1.00		
2.00	City: CARROLLTON			State: IL		Zip Code: 62016		County: GREENE 2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		THOMAS H BOYD CRITICAL ACC HOSPITAL	141300	99914	1	07/12/1999	N	O	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		THOMAS H BOYD CRITICAL ACC SWING BED	14Z300	99914		07/12/1999	N	O	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		GREENE COUNTY RHC	143403	99914		06/22/1995	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)						09/01/2020	08/31/2021		
21.00	Type of Control (see instructions)						2			
							1.00	2.00		
							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.					N	N			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			
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			
22.03	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		
22.04	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		
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			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet S-2
Part I
Date/Time Prepared:
1/31/2022 10:41 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.	0	0	0	0	0	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	0	25.00
					Urban/Rural S 1.00	Date of Geogr 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: 1.00	Ending: 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.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N 1.00	Y/N 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)					N	N	40.00
					V 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1300		Period: From 09/01/2020 To 08/31/2021		Worksheet S-2 Part I Date/Time Prepared: 1/31/2022 10:41 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)					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) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
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
			0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet S-2
Part I
Date/Time Prepared:
1/31/2022 10:41 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	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.					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)					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.					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)					76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1300	Period: From 09/01/2020 To 08/31/2021	Worksheet S-2 Part I Date/Time Prepared: 1/31/2022 10:41 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		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)	Y		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	Y	Y	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1300	Period: From 09/01/2020 To 08/31/2021	Worksheet S-2 Part I Date/Time Prepared: 1/31/2022 10:41 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.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	120,451	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1300		Period: From 09/01/2020 To 08/31/2021		Worksheet S-2 Part I Date/Time Prepared: 1/31/2022 10:41 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:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							146.00	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	Y	Y	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)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1300		Period: From 09/01/2020 To 08/31/2021		Worksheet S-2 Part II Date/Time Prepared: 1/31/2022 10:41 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				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y					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	12/16/2021	Y	12/16/2021		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1300	Period: From 09/01/2020 To 08/31/2021	Worksheet S-2 Part II Date/Time Prepared: 1/31/2022 10:41 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		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.		Y	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet S-2
Part II
Date/Time Prepared:
1/31/2022 10:41 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.	SIGNING DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet S-3
Part I
Date/Time Prepared:
1/31/2022 10:41 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	25	9,125	8,803.00	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)		25	9,125	8,803.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	8,803.00	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 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				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: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet S-3
Part I
Date/Time Prepared:
1/31/2022 10:41 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)	240	6	390			1.00
2.00	HMO and other (see instructions)	44	10				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	577	0	631			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	290			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	817	6	1,311			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)	817	6	1,311	0.00	110.19	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	RHC (CONSOLIDATED)	2,411	0	9,461	0.00	14.88	26.00
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	125.07	27.00
28.00	Observation Bed Days		0	113			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: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet S-3
Part I
Date/Time Prepared:
1/31/2022 10:41 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	82	1	132	1.00
2.00 HMO and other (see instructions)			12	4		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	82	1	132	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 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1300 Component CCN: 14-3403		Period: From 09/01/2020 To 08/31/2021		Worksheet S-8 Date/Time Prepared: 1/31/2022 10:41 am	
		RHC I		Cost			
		1.00					
1.00	Clinic Address and Identification						
	Street	800 SCHOOL STREET 1.00					
		City	State	ZIP Code			
		1.00	2.00	3.00			
2.00	City, State, ZIP Code, County	CARROLLTON		IL	62016	2.00	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0		3.00	
		Grant Award		Date			
		1.00		2.00			
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)	4.00					
5.00	Migrant Health Center (Section 329(d), PHS Act)	5.00					
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	6.00					
7.00	Appalachian Regional Commission	7.00					
8.00	Look-Alikes	8.00					
9.00	OTHER (SPECIFY)	9.00					
		1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0		10.00	
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)							
11.00	CLINIC	08:00	16:00	07:00	19:00	07:00	11.00
		1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?	Y				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y		4		13.00	
		Provider name		CCN number			
		1.00		2.00			
14.00	RHC/FQHC name, CCN number	GREENE COUNTY RURAL HEALTHC CLINIC		143403		14.00	
14.01		THOMAS H BOYD RURAL HEALTH CLINIC		143475		14.01	
14.02		BOYD-FILLAGER CLINIC - GREENFIELD		143474		14.02	
14.03		RURAL HEALTH CENTER OF ROODHOUSE		143476		14.03	
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	15.00					

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1300

Period:

Worksheet S-8

Component CCN: 14-3403

From 09/01/2020
To 08/31/2021Date/Time Prepared:
1/31/2022 10:41 am

						RHC I		Cost		
				County						
				4.00						
2.00	City, State, ZIP Code, County			GREENE COUNTY			2.00			
				Tuesday		Wednesday		Thursday		
				to		from to		from to		
				6.00		7.00 8.00		9.00 10.00		
11.00	Facility hours of operations (1)									11.00
	CLINIC			19:00	07:00	19:00	07:00	19:00		
				Friday		Saturday				
				from to		from to				
				11.00 12.00		13.00 14.00				
11.00	Facility hours of operations (1)									
	CLINIC			07:00	19:00	08:00	16:00	11.00		

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021

Worksheet S-10

Date/Time Prepared:
1/31/2022 10:41 am

			1/31/2022 10:41 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)		0.681617	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		2,651,338	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		3,563,454	6.00
7.00	Medicaid cost (line 1 times line 6)		2,428,911	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
			1.00	2.00
			Total (col. 1 + col. 2)	
			3.00	
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	630	111,402	112,032
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	429	111,402	111,831
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	429	111,402	111,831
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		324,991	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		166,884	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		256,745	
28.00	Non-Medicare bad debt expense (see instructions)		68,246	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		136,379	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		248,210	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		248,210	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-1300		Period: From 09/01/2020 To 08/31/2021		Worksheet A Date/Time Prepared: 1/31/2022 10:41 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	NEW CAP REL COSTS-BLDG & FIXT				355,605		355,605		-290,566		65,039		1.00	
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.				0		0		32,577		32,577		1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				0		0		418,850		418,850		2.00	
3.00	00300	OTHER CAPITAL RELATED COSTS				0		0		0		0		3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			0	954,475		954,475		192,534		1,147,009		4.00	
5.00	00500	ADMINISTRATIVE & GENERAL			992,942	985,679		1,978,621		189,468		2,168,089		5.00	
7.00	00700	OPERATION OF PLANT			93,103	132,269		225,372		13,884		239,256		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE			29,144	7,018		36,162		0		36,162		8.00	
9.00	00900	HOUSEKEEPING			68,188	37,631		105,819		3,725		109,544		9.00	
10.00	01000	DIETARY			163,411	61,354		224,765		0		224,765		10.00	
11.00	01100	CAFETERIA			0	0		0		0		0		11.00	
13.00	01300	NURSING ADMINISTRATION			286,142	448,151		734,293		-12,610		721,683		13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY			28,529	70,568		99,097		0		99,097		14.00	
15.00	01500	PHARMACY			0	353,474		353,474		0		353,474		15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY			71,719	45,205		116,924		0		116,924		16.00	
	INPATIENT ROUTINE SERVICE COST CENTERS														
30.00	03000	ADULTS & PEDIATRICS			1,217,631	263,101		1,480,732		-56,171		1,424,561		30.00	
	ANCILLARY SERVICE COST CENTERS														
54.00	05400	RADIOLOGY-DIAGNOSTIC			389,449	262,623		652,072		-20,745		631,327		54.00	
60.00	06000	LABORATORY			496,418	513,457		1,009,875		1,547		1,011,422		60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.			0	10,821		10,821		1,411		12,232		63.00	
64.00	06400	INTRAVENOUS THERAPY			0	0		0		0		0		64.00	
66.00	06600	PHYSICAL THERAPY			289,941	58,980		348,921		-14,295		334,626		66.00	
67.00	06700	OCCUPATIONAL THERAPY			54,897	5,497		60,394		6,690		67,084		67.00	
68.00	06800	SPEECH PATHOLOGY			0	2,340		2,340		7,605		9,945		68.00	
69.00	06900	ELECTROCARDIOLOGY			0	22,800		22,800		19,512		42,312		69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS			0	0		0		92,987		92,987		71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS			0	0		0		0		0		73.00	
	OUTPATIENT SERVICE COST CENTERS														
88.00	08800	RURAL HEALTH CLINIC			1,456,956	517,627		1,974,583		-366,246		1,608,337		88.00	
90.00	09000	CLINIC			267,546	60,048		327,594		0		327,594		90.00	
91.00	09100	EMERGENCY			1,051,273	920,114		1,971,387		-109,277		1,862,110		91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)												92.00	
	OTHER REIMBURSABLE COST CENTERS														
95.00	09500	AMBULANCE SERVICES			544,677	199,010		743,687		-43,822		699,865		95.00	
	SPECIAL PURPOSE COST CENTERS														
113.00	11300	INTEREST EXPENSE				64,475		64,475		-64,475		0		113.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)			7,501,966	6,352,322		13,854,288		2,583		13,856,871		118.00	
	NONREIMBURSABLE COST CENTERS														
192.00	19200	PHYSICIANS' PRIVATE OFFICES			0	882		882		0		882		192.00	
194.00	07951	WELLNESS			72,305	2,491		74,796		-2,583		72,213		194.00	
200.00		TOTAL (SUM OF LINES 118 through 199)			7,574,271	6,355,695		13,929,966		0		13,929,966		200.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021

Worksheet A

Date/Time Prepared:
1/31/2022 10:41 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-5,472	59,567	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	32,577	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-1,833	417,017	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,793	1,140,216	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-221,684	1,946,405	5.00
7.00	00700	OPERATION OF PLANT	0	239,256	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	36,162	8.00
9.00	00900	HOUSEKEEPING	0	109,544	9.00
10.00	01000	DIETARY	-28,594	196,171	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	721,683	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	99,097	14.00
15.00	01500	PHARMACY	-100,961	252,513	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,737	114,187	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-60,665	1,363,896	30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	631,327	54.00
60.00	06000	LABORATORY	0	1,011,422	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	12,232	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	334,626	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67,084	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,945	68.00
69.00	06900	ELECTROCARDIOLOGY	-22,800	19,512	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	92,987	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	1,608,337	88.00
90.00	09000	CLINIC	-244,839	82,755	90.00
91.00	09100	EMERGENCY	-164,526	1,697,584	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-353,526	346,339	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,214,430	12,642,441	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	882	192.00
194.00	07951	WELLNESS	0	72,213	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,214,430	12,715,536	200.00

RECLASSIFICATIONS

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-6

Date/Time Prepared:
1/31/2022 10:41 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	0	6,380		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	304,916		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	3,695		3.00
	0		0	314,991		
	B - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	34,768		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	29,707		2.00
	0		0	64,475		
	C - EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	17,844	1,668		1.00
2.00		0.00	0	0		2.00
	0		17,844	1,668		
	D - RHC ADMIN COSTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	168,288		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	33,249		2.00
3.00	OPERATION OF PLANT	7.00	0	9,334		3.00
	0		0	210,871		
	E - RHC BUSINESS OFFICE AND HOUSEKEEPING					
1.00	ADMINISTRATIVE & GENERAL	5.00	168,836	12,175		1.00
2.00	HOUSEKEEPING	9.00	3,416	309		2.00
	0		172,252	12,484		
	F - RHC LAB TIME					
1.00	LABORATORY	60.00	2,727	231		1.00
2.00	BLOOD STORING, PROCESSING & TRANS.	63.00	1,293	118		2.00
	0		4,020	349		
	G - ER ADMIN TIME					
1.00	ADMINISTRATIVE & GENERAL	5.00	18,656	33,331		1.00
	0		18,656	33,331		
	H - LEASE EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	8,207		1.00
	0		0	8,207		
	I - PROPERTY TAXES					
1.00	CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	0	24,212		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	2,514		2.00
3.00	WELLNESS	194.00	0	3,603		3.00
	0		0	30,329		
	J - CONTINUING EDUCATION COSTS IN ER					
1.00	RURAL HEALTH CLINIC	88.00	0	13,500		1.00
	0		0	13,500		
	K - PROPERTY INSURANCE					
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	97,369		1.00
2.00		0.00	0	0		2.00
	0		0	97,369		
	L - AMBULANCE OVERHEAD					
1.00	OPERATION OF PLANT	7.00	0	4,550		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	18,060		2.00
	0		0	22,610		
	M - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	92,987		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	92,987		
	N - WELLNESS EMPLOYEE COSTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	5,795	391		1.00
	TOTALS		5,795	391		
	O - PT & ST COSTS					
1.00	OCCUPATIONAL THERAPY	67.00	0	6,690		1.00
2.00	SPEECH PATHOLOGY	68.00	0	7,605		2.00
	TOTALS		0	14,295		
	P - NP COVID SALARIES					
1.00	RURAL HEALTH CLINIC	88.00	12,610	0		1.00
	TOTALS		12,610	0		
500.00	Grand Total: Increases		231,177	917,857		500.00

RECLASSIFICATIONS

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet A-6
Date/Time Prepared:
1/31/2022 10:41 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION EXPENSE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	314,991	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	0		3.00
			0	314,991			
	B - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	64,475	11		1.00
2.00		0.00	0	0	0		2.00
			0	64,475			
	C - EKG SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	7,814	696	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	10,030	972	0		2.00
			17,844	1,668			
	D - RHC ADMIN COSTS						
1.00	RURAL HEALTH CLINIC	88.00	0	210,871	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
			0	210,871			
	E - RHC BUSINESS OFFICE AND HOUSEKEEPING						
1.00	RURAL HEALTH CLINIC	88.00	172,252	12,484	0		1.00
2.00		0.00	0	0	0		2.00
			172,252	12,484			
	F - RHC LAB TIME						
1.00	LABORATORY	60.00	1,293	118	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	2,727	231	0		2.00
			4,020	349			
	G - ER ADMIN TIME						
1.00	EMERGENCY	91.00	18,656	33,331	0		1.00
			18,656	33,331			
	H - LEASE EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	8,207	10		1.00
			0	8,207			
	I - PROPERTY TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	30,329	13		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
			0	30,329			
	J - CONTINUING EDUCATION COSTS IN ER						
1.00	EMERGENCY	91.00	0	13,500	0		1.00
			0	13,500			
	K - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	76,157	0		1.00
2.00	AMBULANCE SERVICES	95.00	0	21,212	0		2.00
			0	97,369			
	L - AMBULANCE OVERHEAD						
1.00	AMBULANCE SERVICES	95.00	0	22,610	0		1.00
2.00		0.00	0	0	0		2.00
			0	22,610			
	M - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	39,454	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,743	0		2.00
3.00	EMERGENCY	91.00	0	43,790	0		3.00
			0	92,987			
	N - WELLNESS EMPLOYEE COSTS						
1.00	WELLNESS	194.00	5,795	391	0		1.00
	TOTALS		5,795	391			
	O - PT & ST COSTS						
1.00	PHYSICAL THERAPY	66.00	0	14,295	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	14,295			
	P - NP COVID SALARIES						
1.00	NURSING ADMINISTRATION	13.00	12,610	0	0		1.00
	TOTALS		12,610	0			
500.00	Grand Total: Decreases		231,177	917,857			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet A-7
Part I
Date/Time Prepared:
1/31/2022 10:41 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	70,514	0	0	0	0	1.00
2.00	Land Improvements	13,680	0	0	0	0	2.00
3.00	Buildings and Fixtures	409,719	419,641	0	419,641	0	3.00
4.00	Building Improvements	237,723	0	0	0	0	4.00
5.00	Fixed Equipment	27,034	7,042	0	7,042	0	5.00
6.00	Movable Equipment	2,458,703	1,175,848	0	1,175,848	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	3,217,373	1,602,531	0	1,602,531	0	8.00
9.00	Reconciling Items	0	-1,864,212	0	-1,864,212	0	9.00
10.00	Total (line 8 minus line 9)	3,217,373	3,466,743	0	3,466,743	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	70,514	0				1.00
2.00	Land Improvements	13,680	0				2.00
3.00	Buildings and Fixtures	829,360	0				3.00
4.00	Building Improvements	237,723	0				4.00
5.00	Fixed Equipment	34,076	0				5.00
6.00	Movable Equipment	3,634,551	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	4,819,904	0				8.00
9.00	Reconciling Items	-1,864,212	0				9.00
10.00	Total (line 8 minus line 9)	6,684,116	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet A-7
Part II
Date/Time Prepared:
1/31/2022 10:41 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	NEW CAP REL COSTS-BLDG & FIXT	355,605	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	355,605	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	355,605				1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	355,605				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet A-7
Part III
Date/Time Prepared:
1/31/2022 10:41 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	NEW CAP REL COSTS-BLDG & FIXT	1,096,257	0	1,096,257	0.250847	24,425	1.00	
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	89,096	0	89,096	0.020387	1,985	1.01	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3,634,551	449,690	3,184,861	0.728766	70,959	2.00	
3.00	Total (sum of lines 1-2)	4,819,904	449,690	4,370,214	1.000000	97,369	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	24,425	35,142	0	1.00	
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0	1,985	6,380	0	1.01	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	70,959	304,916	8,207	2.00	
3.00	Total (sum of lines 1-2)	0	0	97,369	346,438	8,207	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	NEW CAP REL COSTS-BLDG & FIXT	0	24,425	0	0	59,567	1.00	
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	1,985	24,212	0	32,577	1.01	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	32,935	70,959	0	0	417,017	2.00	
3.00	Total (sum of lines 1-2)	32,935	97,369	24,212	0	509,161	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8

Date/Time Prepared:
1/31/2022 10:41 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT NON HOSP. (chapter 2)			0 CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-1,833	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-1,567	ADMINISTRATIVE & GENERAL	5.00	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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-4,404	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-447,991			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-28,594	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,737	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	*** Cost Center Deleted ***	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT NON HOSP.		0	CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW 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

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8

Date/Time Prepared:
1/31/2022 10:41 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	
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	HEALTHLINK FEES - HOSPITAL	A	12,178	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	PHYSICIAN BENEFITS	A	-6,793	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	MISC INC - ADMIN	B	-2,450	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISC INC - CPR CLASSES	B	-330	AMBULANCE SERVICES	95.00	0	33.03
33.04	HEALTH FAIR	B	-7,124	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	IHA LOBBYING DUES	A	-4,589	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	AMBULANCE SUBSIDY - OPERATIONS	B	-353,196	AMBULANCE SERVICES	95.00	0	33.06
33.07	MEDICAID ASSESSMENT TAX	A	-213,728	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	GOODWILL AMORTIZATION	A	-5,472	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.08
33.09	ENT RETAIL SALES	A	-44,839	CLINIC	90.00	0	33.09
33.10	340B EXPENSE	A	-100,961	PHARMACY	15.00	0	33.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,214,430				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8-2

Date/Time Prepared:
1/31/2022 10:41 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,187,918	164,526	1,023,392	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	60,665	60,665	0	0	0	2.00
3.00	90.00	CLINIC	200,000	200,000	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	22,800	22,800	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,471,383	447,991	1,023,392			200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	164,526		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	60,665		2.00
3.00	90.00	CLINIC	0	0	0	200,000		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	22,800		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	447,991		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1300		Period: From 09/01/2020 To 08/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/31/2022 10:41 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					21	1.00
2.00	Line 1 multiplied by 15 hours per week					315	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					53	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.65	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	89.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	81.33	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.67	40.67	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					7,238	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					7,238	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					7,238	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					81.33	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					25,619	22.00
23.00	Total salary equivalency (see instructions)					25,619	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					2,156	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					2,156	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					299	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					2,455	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					2,455	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					299	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1300		Period: From 09/01/2020 To 08/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/31/2022 10:41 am		
				Occupational Therapy		Cost		
						1.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	81.33	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						25,619	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						2,455	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						28,074	63.00
64.00	Total cost of outside supplier services (from your records)						6,690	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						2,156	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						299	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						2,455	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						299	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						299	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1300		Period: From 09/01/2020 To 08/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/31/2022 10:41 am	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					34	1.00
2.00	Line 1 multiplied by 15 hours per week					510	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					61	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.65	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	96.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	78.15	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.08	39.08	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					7,541	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					7,541	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					7,541	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					78.15	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					39,857	22.00
23.00	Total salary equivalency (see instructions)					39,857	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					2,384	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					2,384	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					345	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					2,729	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					2,729	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					345	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS				Provider CCN: 14-1300		Period: From 09/01/2020 To 08/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/31/2022 10:41 am		
						Speech Pathology		Cost		
								1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)							0 46.00		
						Therapists	Assistants	Aides	Trainees	
						1.00	2.00	3.00	4.00	
						Total		5.00		
PART V - OVERTIME COMPUTATION										
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)					0.00	0.00	0.00	0.00	0.00
48.00	Overtime rate (see instructions)					0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)					0.00	0.00	0.00	0.00	49.00
CALCULATION OF LIMIT										
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)					0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)					0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE										
52.00	Adjusted hourly salary equivalency amount (see instructions)					78.15	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)					0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)					0	0	0	0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)					0	0	0	0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)					0	0	0	0	56.00
								1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT										
57.00	Salary equivalency amount (from line 23)							39,857 57.00		
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							2,729 58.00		
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)							0 59.00		
60.00	Overtime allowance (from column 5, line 56)							0 60.00		
61.00	Equipment cost (see instructions)							0 61.00		
62.00	Supplies (see instructions)							0 62.00		
63.00	Total allowance (sum of lines 57-62)							42,586 63.00		
64.00	Total cost of outside supplier services (from your records)							7,605 64.00		
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)							0 65.00		
LINE 33 CALCULATION										
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others							2,384 100.00		
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							345 100.01		
100.02	Line 33 = line 28 = sum of lines 26 and 27							2,729 100.02		
LINE 34 CALCULATION										
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							345 101.00		
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0 101.01		
101.02	Line 34 = sum of lines 27 and 31							345 101.02		
LINE 35 CALCULATION										
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0 102.00		
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others							0 102.01		
102.02	Line 35 = sum of lines 31 and 32							0 102.02		

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part I
Date/Time Prepared:
1/31/2022 10:41 am

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	BLDG & FIXT NON HOSP.	NEW MVBLE EQUIP	
			0	1.00	1.01	2.00	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	59,567	59,567			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.	32,577	0	32,577		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	417,017			417,017	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,140,216			0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,946,405	6,686	3,979	50,698	185,733
7.00	00700	OPERATION OF PLANT	239,256	2,186	0	827	14,649
8.00	00800	LAUNDRY & LINEN SERVICE	36,162	2,099	0	2,121	4,586
9.00	00900	HOUSEKEEPING	109,544	583	0	0	11,266
10.00	01000	DIETARY	196,171	6,193	0	0	25,712
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	721,683	0	0	0	43,038
14.00	01400	CENTRAL SERVICES & SUPPLY	99,097	1,074	0	0	4,489
15.00	01500	PHARMACY	252,513	807	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	114,187	1,147	0	20,334	11,284
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,363,896	18,654	0	15,817	180,811
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	631,327	2,730	0	156,839	59,699
60.00	06000	LABORATORY	1,011,422	1,767	0	115,645	78,334
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,232	0	0	0	203
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	334,626	3,237	0	51,217	45,620
67.00	06700	OCCUPATIONAL THERAPY	67,084	549	0	0	8,638
68.00	06800	SPEECH PATHOLOGY	9,945	50	0	0	0
69.00	06900	ELECTROCARDIOLOGY	19,512	0	0	0	2,808
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	92,987	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,608,337	4,104	0	0	203,692
90.00	09000	CLINIC	82,755	1,321	0	2,062	10,628
91.00	09100	EMERGENCY	1,697,584	5,484	0	1,457	152,860
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	346,339	896	0	0	85,701
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,642,441	59,567	3,979	417,017	1,129,751
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	882	0	28,598	0	0
194.00	07951	WELLNESS	72,213	0	0	0	10,465
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	12,715,536	59,567	32,577	417,017	1,140,216

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part I
Date/Time Prepared:
1/31/2022 10:41 am

Cost Center Description			Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,193,501	2,193,501				5.00
7.00	00700	OPERATION OF PLANT	256,918	53,559	310,477			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	44,968	9,374	12,856	67,198		8.00
9.00	00900	HOUSEKEEPING	121,393	25,306	3,568	10,634	160,901	9.00
10.00	01000	DIETARY	228,076	47,546	37,929	1,233	17,355	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	764,721	159,419	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	104,660	21,818	6,575	0	0	14.00
15.00	01500	PHARMACY	253,320	52,809	4,944	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	146,952	30,635	7,027	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,579,178	329,207	114,259	37,847	94,450	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	850,595	177,321	16,719	0	11,519	54.00
60.00	06000	LABORATORY	1,207,168	251,655	10,821	0	10,751	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,435	2,592	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	434,700	90,621	19,824	4,762	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	76,271	15,900	3,361	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,995	2,084	305	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	22,320	4,653	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	92,987	19,385	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,816,133	378,604	25,132	525	11,519	88.00
90.00	09000	CLINIC	96,766	20,173	8,089	0	0	90.00
91.00	09100	EMERGENCY	1,857,385	387,205	33,584	12,197	11,519	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	432,936	90,253	5,484	0	3,788	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,603,378	2,170,119	310,477	67,198	160,901	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29,480	6,146	0	0	0	192.00
194.00	07951	WELLNESS	82,678	17,236	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,715,536	2,193,501	310,477	67,198	160,901	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part I
Date/Time Prepared:
1/31/2022 10:41 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW 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	332,139					10.00
11.00	01100	CAFETERIA	237,797	237,797				11.00
13.00	01300	NURSING ADMINISTRATION	0	8,890	933,030			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,973	0	136,026		14.00
15.00	01500	PHARMACY	0	0	0	0	311,073	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,766	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	94,342	60,607	666,261	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,028	0	0	0	54.00
60.00	06000	LABORATORY	0	25,768	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	60	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	15,256	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	390	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	811	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	136,026	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	311,073	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	20,632	0	0	0	88.00
90.00	09000	CLINIC	0	4,205	0	0	0	90.00
91.00	09100	EMERGENCY	0	37,210	266,769	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	34,117	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	332,139	233,713	933,030	136,026	311,073	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	WELLNESS	0	4,084	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	332,139	237,797	933,030	136,026	311,073	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part I
Date/Time Prepared:
1/31/2022 10:41 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.					1.01
2.00	00200	NEW 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	190,380				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	36,648	3,012,799	-85,242	2,927,557	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,861	1,088,043	0	1,088,043	54.00
60.00	06000	LABORATORY	25,177	1,531,340	0	1,531,340	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	15,087	0	15,087	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	905,069	905,069	64.00
66.00	06600	PHYSICAL THERAPY	5,229	570,392	0	570,392	66.00
67.00	06700	OCCUPATIONAL THERAPY	886	96,808	0	96,808	67.00
68.00	06800	SPEECH PATHOLOGY	89	12,473	0	12,473	68.00
69.00	06900	ELECTROCARDIOLOGY	0	27,784	0	27,784	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	248,398	0	248,398	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	311,073	0	311,073	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,252,545	0	2,252,545	88.00
90.00	09000	CLINIC	0	129,233	0	129,233	90.00
91.00	09100	EMERGENCY	89,166	2,695,035	-819,827	1,875,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	18,324	584,902	0	584,902	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	190,380	12,575,912	0	12,575,912	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	35,626	0	35,626	192.00
194.00	07951	WELLNESS	0	103,998	0	103,998	194.00
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	190,380	12,715,536	0	12,715,536	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part II
Date/Time Prepared:
1/31/2022 10:41 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			NEW BLDG & FIXT	BLDG & FIXT NON HOSP.	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	2A	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	6,686	3,979	50,698	61,363 5.00
7.00	00700	OPERATION OF PLANT	0	2,186	0	827	3,013 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,099	0	2,121	4,220 8.00
9.00	00900	HOUSEKEEPING	0	583	0	0	583 9.00
10.00	01000	DIETARY	0	6,193	0	0	6,193 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,074	0	0	1,074 14.00
15.00	01500	PHARMACY	0	807	0	0	807 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,147	0	20,334	21,481 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	18,654	0	15,817	34,471 30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,730	0	156,839	159,569 54.00
60.00	06000	LABORATORY	0	1,767	0	115,645	117,412 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
66.00	06600	PHYSICAL THERAPY	0	3,237	0	51,217	54,454 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	549	0	0	549 67.00
68.00	06800	SPEECH PATHOLOGY	0	50	0	0	50 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	20,759	4,104	0	0	24,863 88.00
90.00	09000	CLINIC	0	1,321	0	2,062	3,383 90.00
91.00	09100	EMERGENCY	0	5,484	0	1,457	6,941 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	896	0	0	896 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,759	59,567	3,979	417,017	501,322 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	28,598	0	28,598 192.00
194.00	07951	WELLNESS	0	0	0	0	0 194.00
200.00		Cross Foot Adjustments					0 200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	20,759	59,567	32,577	417,017	529,920 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part II
Date/Time Prepared:
1/31/2022 10:41 am

Cost Center Description			EMPLOYEE BENEFITS & GENERAL	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	61,363				5.00
7.00	00700	OPERATION OF PLANT	0	1,498	4,511			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	262	187	4,669		8.00
9.00	00900	HOUSEKEEPING	0	708	52	739	2,082	9.00
10.00	01000	DIETARY	0	1,330	551	86	225	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,460	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	610	96	0	0	14.00
15.00	01500	PHARMACY	0	1,477	72	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	857	102	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	9,210	1,659	2,630	1,222	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,961	243	0	149	54.00
60.00	06000	LABORATORY	0	7,040	157	0	139	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	73	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	2,535	288	331	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	445	49	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	58	4	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	130	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	542	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	10,592	365	36	149	88.00
90.00	09000	CLINIC	0	564	118	0	0	90.00
91.00	09100	EMERGENCY	0	10,832	488	847	149	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	2,525	80	0	49	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	60,709	4,511	4,669	2,082	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	172	0	0	0	192.00
194.00	07951	WELLNESS	0	482	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	61,363	4,511	4,669	2,082	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part II
Date/Time Prepared:
1/31/2022 10:41 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW 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	8,385					10.00
11.00	01100	CAFETERIA	6,003	6,003				11.00
13.00	01300	NURSING ADMINISTRATION	0	224	4,684			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	75	0	1,855		14.00
15.00	01500	PHARMACY	0	0	0	0	2,356	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	146	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,382	1,531	3,345	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	430	0	0	0	54.00
60.00	06000	LABORATORY	0	650	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	385	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	20	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,855	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,356	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	521	0	0	0	88.00
90.00	09000	CLINIC	0	106	0	0	0	90.00
91.00	09100	EMERGENCY	0	939	1,339	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	861	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,385	5,900	4,684	1,855	2,356	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	WELLNESS	0	103	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,385	6,003	4,684	1,855	2,356	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part II
Date/Time Prepared:
1/31/2022 10:41 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.					1.01
2.00	00200	NEW 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	22,586				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,348	60,798	0	60,798	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,763	167,115	0	167,115	54.00
60.00	06000	LABORATORY	2,987	128,385	0	128,385	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	75	0	75	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	620	58,613	0	58,613	66.00
67.00	06700	OCCUPATIONAL THERAPY	105	1,158	0	1,158	67.00
68.00	06800	SPEECH PATHOLOGY	11	123	0	123	68.00
69.00	06900	ELECTROCARDIOLOGY	0	150	0	150	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,397	0	2,397	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,356	0	2,356	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	36,526	0	36,526	88.00
90.00	09000	CLINIC	0	4,171	0	4,171	90.00
91.00	09100	EMERGENCY	10,578	32,113	0	32,113	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,174	6,585	0	6,585	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,586	500,565	0	500,565	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	28,770	0	28,770	192.00
194.00	07951	WELLNESS	0	585	0	585	194.00
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	22,586	529,920	0	529,920	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/31/2022 10:41 am

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation		
			NEW BLDG & FIXT (SQUARE FEET)	BLDG & FIXT NON HOSP. (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
			1.00	1.01	2.00				4.00
	GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	37,117					1.00	
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	7,074				1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			346,058			2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	7,246,701		4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	4,166	864	42,071	1,180,434	-2,193,501	5.00	
7.00	00700	OPERATION OF PLANT	1,362	0	686	93,103	0	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	1,308	0	1,760	29,144	0	8.00	
9.00	00900	HOUSEKEEPING	363	0	0	71,604	0	9.00	
10.00	01000	DIETARY	3,859	0	0	163,411	0	10.00	
11.00	01100	CAFETERIA	0	0	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	0	0	0	273,532	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	669	0	0	28,529	0	14.00	
15.00	01500	PHARMACY	503	0	0	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	715	0	16,874	71,719	0	16.00	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,625	0	13,126	1,149,151	0	30.00	
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,701	0	130,152	379,419	0	54.00	
60.00	06000	LABORATORY	1,101	0	95,967	497,853	0	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,293	0	63.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
66.00	06600	PHYSICAL THERAPY	2,017	0	42,502	289,941	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	342	0	0	54,897	0	67.00	
68.00	06800	SPEECH PATHOLOGY	31	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,844	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,557	0	0	1,294,587	0	88.00	
90.00	09000	CLINIC	823	0	1,711	67,546	0	90.00	
91.00	09100	EMERGENCY	3,417	0	1,209	971,507	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	558	0	0	544,677	0	95.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,117	864	346,058	7,180,191	-2,193,501	118.00	
	NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,210	0	0	0	192.00	
194.00	07951	WELLNESS	0	0	0	66,510	0	194.00	
200.00		Cross Foot Adjustments						200.00	
201.00		Negative Cost Centers						201.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	59,567	32,577	417,017	1,140,216		202.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	1.604844	4.605174	1.205049	0.157343		203.00	
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00	
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/31/2022 10:41 am

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,522,035				5.00
7.00	00700	OPERATION OF PLANT	256,918	31,589			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	44,968	1,308	38,041		8.00
9.00	00900	HOUSEKEEPING	121,393	363	6,020	62,860	9.00
10.00	01000	DIETARY	228,076	3,859	698	6,780	15,913
11.00	01100	CAFETERIA	0	0	0	0	11,393
13.00	01300	NURSING ADMINISTRATION	764,721	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	104,660	669	0	0	0
15.00	01500	PHARMACY	253,320	503	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	146,952	715	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,579,178	11,625	21,425	36,900	4,520
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	850,595	1,701	0	4,500	0
60.00	06000	LABORATORY	1,207,168	1,101	0	4,200	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,435	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	434,700	2,017	2,696	0	0
67.00	06700	OCCUPATIONAL THERAPY	76,271	342	0	0	0
68.00	06800	SPEECH PATHOLOGY	9,995	31	0	0	0
69.00	06900	ELECTROCARDIOLOGY	22,320	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	92,987	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,816,133	2,557	297	4,500	0
90.00	09000	CLINIC	96,766	823	0	0	0
91.00	09100	EMERGENCY	1,857,385	3,417	6,905	4,500	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	432,936	558	0	1,480	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,409,877	31,589	38,041	62,860	15,913
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29,480	0	0	0	0
194.00	07951	WELLNESS	82,678	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	2,193,501	310,477	67,198	160,901	332,139
203.00		Unit cost multiplier (Wkst. B, Part I)	0.208467	9.828643	1.766463	2.559672	20.872180
204.00		Cost to be allocated (per Wkst. B, Part II)	61,363	4,511	4,669	2,082	8,385
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005832	0.142803	0.122736	0.033121	0.526928
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/31/2022 10:41 am

Cost Center Description			CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW 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	7,918					11.00
13.00	01300	NURSING ADMINISTRATION	296	2,826				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	99	0	100			14.00
15.00	01500	PHARMACY	0	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	192	0	0	0	65,975	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,018	2,018	0	0	12,700	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	567	0	0	0	5,150	54.00
60.00	06000	LABORATORY	858	0	0	0	8,725	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	508	0	0	0	1,812	66.00
67.00	06700	OCCUPATIONAL THERAPY	13	0	0	0	307	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	31	68.00
69.00	06900	ELECTROCARDIOLOGY	27	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	687	0	0	0	0	88.00
90.00	09000	CLINIC	140	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,239	808	0	0	30,900	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,136	0	0	0	6,350	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,782	2,826	100	100	65,975	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	WELLNESS	136	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	237,797	933,030	136,026	311,073	190,380	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.032458	330.159236	1,360.260000	3,110.730000	2.885638	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,003	4,684	1,855	2,356	22,586	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.758146	1.657466	18.550000	23.560000	0.342342	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-2

Date/Time Prepared:
1/31/2022 10:41 am

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0
7.00		IV THERAPY		1	30.00	-85,242
8.00		IV THERAPY		1	64.00	905,069
9.00		IV THERAPY		1	91.00	-819,827

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/31/2022 10:41 am

			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs	
					Total Costs	Total Costs
					RCE Disallowance	
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,927,557		2,927,557	0
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,088,043		1,088,043	0
60.00	06000	LABORATORY	1,531,340		1,531,340	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	15,087		15,087	0
64.00	06400	INTRAVENOUS THERAPY	905,069		905,069	0
66.00	06600	PHYSICAL THERAPY	570,392	0	570,392	0
67.00	06700	OCCUPATIONAL THERAPY	96,808	0	96,808	0
68.00	06800	SPEECH PATHOLOGY	12,473	0	12,473	0
69.00	06900	ELECTROCARDIOLOGY	27,784		27,784	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	248,398		248,398	0
73.00	07300	DRUGS CHARGED TO PATIENTS	311,073		311,073	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,252,545		2,252,545	0
90.00	09000	CLINIC	129,233		129,233	0
91.00	09100	EMERGENCY	1,875,208		1,875,208	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	286,819		286,819	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	584,902		584,902	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	12,862,731	0	12,862,731	0
201.00		Less Observation Beds	286,819		286,819	0
202.00		Total (see instructions)	12,575,912	0	12,575,912	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/31/2022 10:41 am

			Title XVIII		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	918,395		918,395		30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	122,041	4,549,206	4,671,247	0.232923	0.000000
60.00	06000	LABORATORY	232,345	3,978,611	4,210,956	0.363656	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,900	49,466	62,366	0.241911	0.000000
64.00	06400	INTRAVENOUS THERAPY	1,382	660,551	661,933	1.367312	0.000000
66.00	06600	PHYSICAL THERAPY	155,075	1,100,143	1,255,218	0.454417	0.000000
67.00	06700	OCCUPATIONAL THERAPY	117,139	95,441	212,580	0.455396	0.000000
68.00	06800	SPEECH PATHOLOGY	7,128	12,062	19,190	0.649974	0.000000
69.00	06900	ELECTROCARDIOLOGY	7,161	357,961	365,122	0.076095	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	285,863	201,516	487,379	0.509661	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	336,427	506,077	842,504	0.369224	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	37,988	1,934,485	1,972,473		88.00
90.00	09000	CLINIC	0	64,420	64,420	2.006101	0.000000
91.00	09100	EMERGENCY	4,436	1,021,304	1,025,740	1.828151	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	138,234	138,234	2.074880	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	1,542,362	1,542,362	0.379225	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	2,238,280	16,211,839	18,450,119		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	2,238,280	16,211,839	18,450,119		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/31/2022 10:41 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
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 PATIENTS	0.000000			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part II
Date/Time Prepared:
1/31/2022 10:41 am

Cost Center Description			Title XVIII		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								
54.00	05400	RADIOLOGY-DIAGNOSTIC	167,115	4,671,247	0.035775	32,457	1,161	54.00
60.00	06000	LABORATORY	128,385	4,210,956	0.030488	86,297	2,631	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	75	62,366	0.001203	6,344	8	63.00
64.00	06400	INTRAVENOUS THERAPY	0	661,933	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	58,613	1,255,218	0.046695	17,320	809	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,158	212,580	0.005447	10,207	56	67.00
68.00	06800	SPEECH PATHOLOGY	123	19,190	0.006410	762	5	68.00
69.00	06900	ELECTROCARDIOLOGY	150	365,122	0.000411	1,617	1	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,397	487,379	0.004918	84,473	415	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,356	842,504	0.002796	97,326	272	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	36,526	1,972,473	0.018518	0	0	88.00
90.00	09000	CLINIC	4,171	64,420	0.064747	0	0	90.00
91.00	09100	EMERGENCY	32,113	1,025,740	0.031307	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,956	138,234	0.043086	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	439,138	15,989,362		336,803	5,358	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021

Worksheet D
Part IV
Date/Time Prepared:
1/31/2022 10:41 am

Cost Center Description			Title XVIII		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							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1300		Period: From 09/01/2020 To 08/31/2021		Worksheet D Part IV Date/Time Prepared: 1/31/2022 10:41 am	
			Title XVIII		Hospital		Cost	
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								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,671,247	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	4,210,956	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	62,366	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	661,933	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,255,218	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	212,580	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	19,190	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	365,122	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	487,379	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	842,504	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,972,473	0.000000	88.00
90.00	09000	CLINIC	0	0	0	64,420	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	1,025,740	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	138,234	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	15,989,362		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021

Worksheet D
Part IV
Date/Time Prepared:
1/31/2022 10:41 am

Cost Center Description		Title XVIII		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						
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	32,457	0	0	0
60.00	06000 LABORATORY	0.000000	86,297	0	0	0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	6,344	0	0	0
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0
66.00	06600 PHYSICAL THERAPY	0.000000	17,320	0	0	0
67.00	06700 OCCUPATIONAL THERAPY	0.000000	10,207	0	0	0
68.00	06800 SPEECH PATHOLOGY	0.000000	762	0	0	0
69.00	06900 ELECTROCARDIOLOGY	0.000000	1,617	0	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	84,473	0	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	97,326	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0
90.00	09000 CLINIC	0.000000	0	0	0	0
91.00	09100 EMERGENCY	0.000000	0	0	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					
200.00	Total (lines 50 through 199)		336,803	0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part V
Date/Time Prepared:
1/31/2022 10:41 am

			Title XVIII		Hospital		Cost	
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							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232923	0	1,597,509	0	0	54.00
60.00	06000	LABORATORY	0.363656	0	1,586,331	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.241911	0	37,401	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	1.367312	0	288,537	200	0	64.00
66.00	06600	PHYSICAL THERAPY	0.454417	0	354,435	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.455396	0	37,580	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.649974	0	1,078	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.076095	0	176,151	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.509661	0	98,268	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.369224	0	267,011	430	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	2.006101	0	11,737	0	0	90.00
91.00	09100	EMERGENCY	1.828151	0	321,331	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.074880	0	76,984	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.379225		0			95.00
200.00		Subtotal (see instructions)		0	4,854,353	630	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	4,854,353	630	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part V
Date/Time Prepared:
1/31/2022 10:41 am

				Title XVIII	Hospital	Cost
	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					
54.00	05400	RADIOLOGY-DIAGNOSTIC	372,097	0		54.00
60.00	06000	LABORATORY	576,879	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9,048	0		63.00
64.00	06400	INTRAVENOUS THERAPY	394,520	273		64.00
66.00	06600	PHYSICAL THERAPY	161,061	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	17,114	0		67.00
68.00	06800	SPEECH PATHOLOGY	701	0		68.00
69.00	06900	ELECTROCARDIOLOGY	13,404	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	50,083	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	98,587	159		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	23,546	0		90.00
91.00	09100	EMERGENCY	587,442	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	159,733	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	2,464,215	432		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,464,215	432		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1300	Period: From 09/01/2020 To 08/31/2021	Worksheet D-1 Date/Time Prepared: 1/31/2022 10:41 am	
		Title XVIII	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)		1,424	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		503	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)		390	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		142	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)		489	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		36	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)		254	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		240	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)		139	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)		438	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			17.00	
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00	
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		169.71	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		169.71	20.00	
21.00	Total general inpatient routine service cost (see instructions)		2,927,557	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)		6,110	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)		43,106	25.00	
26.00	Total swing-bed cost (see instructions)		1,650,833	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,276,724	27.00	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00	
29.00	Private room charges (excluding swing-bed charges)		0	29.00	
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00	
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00	
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00	
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,276,724	37.00	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		2,538.22	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		609,173	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)		609,173	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021

Worksheet D-1

Date/Time Prepared:
1/31/2022 10:41 am

		Title XVIII		Hospital	Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					132,602 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					741,775 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)					352,813 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,111,740 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,464,553 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)					113 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,538.22 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					286,819 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021

Worksheet D-1

Date/Time Prepared:
1/31/2022 10:41 am

		Title XVIII		Hospital		Cost	
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	60,798	2,927,557	0.020767	286,819	5,956	90.00
91.00	Nursing Program cost	0	2,927,557	0.000000	286,819	0	91.00
92.00	Allied health cost	0	2,927,557	0.000000	286,819	0	92.00
93.00	All other Medical Education	0	2,927,557	0.000000	286,819	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1300	Period: From 09/01/2020 To 08/31/2021	Worksheet D-3 Date/Time Prepared: 1/31/2022 10:41 am	
Cost Center Description		Title XVIII	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		318,501		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.232923	32,457	7,560	54.00
60.00	06000 LABORATORY	0.363656	86,297	31,382	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.241911	6,344	1,535	63.00
64.00	06400 INTRAVENOUS THERAPY	1.367312	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0.454417	17,320	7,871	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.455396	10,207	4,648	67.00
68.00	06800 SPEECH PATHOLOGY	0.649974	762	495	68.00
69.00	06900 ELECTROCARDIOLOGY	0.076095	1,617	123	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.509661	84,473	43,053	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.369224	97,326	35,935	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	2.006101	0	0	90.00
91.00	09100 EMERGENCY	1.828151	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.074880	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		336,803	132,602	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)		336,803		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1300 Component CCN: 14-Z300	Period: From 09/01/2020 To 08/31/2021	Worksheet D-3 Date/Time Prepared: 1/31/2022 10:41 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	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				30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.232923	46,611	10,857	54.00
60.00	06000 LABORATORY	0.363656	72,825	26,483	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.241911	6,556	1,586	63.00
64.00	06400 INTRAVENOUS THERAPY	1.367312	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0.454417	106,521	48,405	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.455396	88,345	40,232	67.00
68.00	06800 SPEECH PATHOLOGY	0.649974	6,112	3,973	68.00
69.00	06900 ELECTROCARDIOLOGY	0.076095	2,310	176	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.509661	161,024	82,068	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.369224	145,414	53,690	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	2.006101	0	0	90.00
91.00	09100 EMERGENCY	1.828151	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.074880	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		635,718	267,470	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)		635,718		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1300	Period: From 09/01/2020 To 08/31/2021	Worksheet E Part B Date/Time Prepared: 1/31/2022 10:41 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,464,647	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,464,647	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		2,489,293	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		32,700	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		631,585	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,825,008	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,825,008	30.00
31.00	Primary payer payments		4,896	31.00
32.00	Subtotal (line 30 minus line 31)		1,820,112	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)		192,037	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		124,824	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		102,375	36.00
37.00	Subtotal (see instructions)		1,944,936	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,944,936	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		1,860,112	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)		84,824	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: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet E-1
Part I
Date/Time Prepared:
1/31/2022 10:41 am

		Title XVIII		Hospital		Cost
		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		665,899		1,860,112	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	07/29/2021	17,986		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)		-17,986		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)		647,913		1,860,112	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		32,228		84,824	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		680,141		1,944,936	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1300

Period:

Worksheet E-1

Component CCN: 14-Z300

From 09/01/2020
To 08/31/2021Part I
Date/Time Prepared:
1/31/2022 10:41 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,658,052		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	05/14/2021	48,414		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)		48,414		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,706,466		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		17,651		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,724,117		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet E-1
Part II
Date/Time Prepared:
1/31/2022 10:41 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1300 Component CCN: 14-Z300	Period: From 09/01/2020 To 08/31/2021	Worksheet E-2 Date/Time Prepared: 1/31/2022 10:41 am	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,479,199	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		270,145	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		577	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,749,344	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,749,344	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		3,066	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,746,278	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		22,161	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,724,117	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,724,117	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		1,706,466	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)		17,651	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparision of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1300	Period: From 09/01/2020 To 08/31/2021	Worksheet E-3 Part V Date/Time Prepared: 1/31/2022 10:41 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		741,775	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		741,775	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		749,193	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		749,193	19.00
20.00	Deductibles (exclude professional component)		88,928	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		660,265	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		660,265	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		30,579	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		19,876	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		16,046	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		680,141	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.98	Recovery of accelerated depreciation.		0	29.98
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		680,141	30.00
30.01	Sequestration adjustment (see instructions)		0	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM			30.03
31.00	Interim payments		647,913	31.00
31.01	Interim payments-PARHM			31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)			32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		32,228	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021

Worksheet G

Date/Time Prepared:
1/31/2022 10:41 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	1,771,342	0	0	0	1.00
2.00	Temporary investments	208,803	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,701,307	0	0	0	4.00
5.00	Other receivable	83,244	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,921,701	0	0	0	6.00
7.00	Inventory	31,871	0	0	0	7.00
8.00	Prepaid expenses	53,778	0	0	0	8.00
9.00	Other current assets	261,030	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)	4,189,674	0	0	0	11.00
FIXED ASSETS						
12.00	Land	70,514	0	0	0	12.00
13.00	Land improvements	13,680	0	0	0	13.00
14.00	Accumulated depreciation	-2,280	0	0	0	14.00
15.00	Buildings	1,067,083	0	0	0	15.00
16.00	Accumulated depreciation	-414,158	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	34,076	0	0	0	19.00
20.00	Accumulated depreciation	-10,423	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	3,634,551	0	0	0	23.00
24.00	Accumulated depreciation	-1,747,695	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	1,864,212	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,509,560	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	16,415	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	16,415	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	8,715,649	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,948,965	0	0	0	37.00
38.00	Salaries, wages, and fees payable	691,083	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	177,714	0	0	0	40.00
41.00	Deferred income	295,801	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	16,055	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,129,618	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	497,204	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	497,204	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,626,822	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	4,088,827	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	4,088,827	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	8,715,649	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021

Worksheet G-1

Date/Time Prepared:
1/31/2022 10:41 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		-977,736		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,066,563				2.00
3.00	Total (sum of line 1 and line 2)		4,088,827		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		4,088,827		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)		4,088,827		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
1/31/2022 10:41 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	273,206		273,206	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	442,035		442,035	5.00
6.00	Swing bed - NF	203,154		203,154	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)	918,395		918,395	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	918,395		918,395	17.00
18.00	Ancillary services	1,277,461	11,511,034	12,788,495	18.00
19.00	Outpatient services	4,436	1,223,958	1,228,394	19.00
20.00	RURAL HEALTH CLINIC	37,988	1,934,485	1,972,473	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,542,362	1,542,362	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	122,969	606,263	729,232	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,361,249	16,818,102	19,179,351	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		13,929,966		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)		13,929,966		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1300

Period:
From 09/01/2020
To 08/31/2021

Worksheet G-3

Date/Time Prepared:
1/31/2022 10:41 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	19,179,351	1.00
2.00	Less contractual allowances and discounts on patients' accounts	6,296,921	2.00
3.00	Net patient revenues (line 1 minus line 2)	12,882,430	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,929,966	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,047,536	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	70,795	6.00
7.00	Income from investments	33,747	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	28,594	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	2,737	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	2,639	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	4,900	22.00
23.00	Governmental appropriations	0	23.00
24.00	340B INCOME	362,408	24.00
24.01	AMBULANCE SUBSIDY	353,196	24.01
24.02	ICHAN & STATE GRANTS	371,431	24.02
24.03	EHR INCENTIVE	17,000	24.03
24.04	FUNDRAISING INCOME	24	24.04
24.05	MISCELLANEOUS INCOME	160,900	24.05
24.06	PT HOME VISIT REVENUE	68,043	24.06
24.50	COVID-19 PHE Funding	4,637,685	24.50
25.00	Total other income (sum of lines 6-24)	6,114,099	25.00
26.00	Total (line 5 plus line 25)	5,066,563	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)	5,066,563	29.00

Health Financial Systems		THOMAS H BOYD CRITICAL ACC HOSPITAL			In Lieu of Form CMS-2552-10	
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS				Provider CCN: 14-1300	Period: From 09/01/2020 To 08/31/2021	Worksheet M-1
				Component CCN: 14-3403		Date/Time Prepared: 1/31/2022 10:41 am
				RHC I		Cost
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	412,104	0	412,104	-30,911	381,193
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	526,483	0	526,483	-75,550	450,933
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	346,467	0	346,467	-2,727	343,740
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	1,285,054	0	1,285,054	-109,188	1,175,866
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	53,000	53,000	0	53,000
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	179,288	179,288	-168,288	11,000
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	232,288	232,288	-168,288	64,000
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,285,054	232,288	1,517,342	-277,476	1,239,866
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	119,071	119,071
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	119,071	119,071
FACILITY OVERHEAD						
29.00	Facility Costs	0	43,976	43,976	-3,125	40,851
30.00	Administrative Costs	171,902	241,363	413,265	-204,716	208,549
31.00	Total Facility Overhead (sum of lines 29 and 30)	171,902	285,339	457,241	-207,841	249,400
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,456,956	517,627	1,974,583	-366,246	1,608,337

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1300

Period:

Worksheet M-1

Component CCN: 14-3403

From 09/01/2020
To 08/31/2021Date/Time Prepared:
1/31/2022 10:41 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	381,193	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	450,933	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	343,740	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,175,866	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	53,000	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	11,000	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	64,000	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,239,866	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	119,071	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	119,071	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	40,851	29.00
30.00	Administrative Costs	0	208,549	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	249,400	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,608,337	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1300

Period:

Worksheet M-2

Component CCN: 14-3403

From 09/01/2020
To 08/31/2021Date/Time Prepared:
1/31/2022 10:41 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.29	3,231	2,940	3,793		1.00
2.00	Physician Assistant	0.00	0	1,470	0		2.00
3.00	Nurse Practitioner	4.56	6,230	1,470	6,703		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.85	9,461		10,496	10,496	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)	5.85	9,461			10,496	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)					1,239,866	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					119,071	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,358,937	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.912379	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					249,400	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					644,208	15.00
16.00	Total overhead (sum of lines 14 and 15)					893,608	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					893,608	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					815,309	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,055,175	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1300 Component CCN: 14-3403	Period: From 09/01/2020 To 08/31/2021	Worksheet M-3 Date/Time Prepared: 1/31/2022 10:41 am	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,055,175	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			30,519	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,024,656	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			10,496	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)			10,496	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			192.90	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	196.46	8.00
9.00	Rate for Program covered visits (see instructions)	192.90	192.90	192.90	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,270	1,141	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	244,983	220,099	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	465,082		16.00
16.01	Total program charges (see instructions)(from contractor's records)		427,643		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		23,135		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		25,160		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.)		302,725		16.04
16.05	Total program cost (see instructions)	0	327,885		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		61,516		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		68,598		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		327,885		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		18,068		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		345,953		22.00
23.00	Allowable bad debts (see instructions)		34,129		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		22,184		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		16,515		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)		368,137		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		241,810		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		126,327		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: 14-1300

Period:

Worksheet M-4

Component CCN: 14-3403

From 09/01/2020
To 08/31/2021Date/Time Prepared:
1/31/2022 10:41 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)	1,175,866	1,175,866	1,175,866	1,175,866	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000132	0.001050	0.000412	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	155	1,235	484	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	9,854	6,684	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	10,009	7,919	484	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,239,866	1,239,866	1,239,866	1,239,866	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	815,309	815,309	815,309	815,309	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.008073	0.006387	0.000390	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	6,582	5,207	318	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	16,591	13,126	802	0	10.00
11.00	Total number of injections/infusions (from your records)	49	390	153	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	338.59	33.66	5.24	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	40	131	22	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	13,544	4,409	115	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)		30,519			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		18,068			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1300 Component CCN: 14-3403	Period: From 09/01/2020 To 08/31/2021	Worksheet M-5 Date/Time Prepared: 1/31/2022 10:41 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		273,715	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		05/14/2021	12,709		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		07/29/2021	44,614		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)		-31,905		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		241,810		4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01			0		5.01
5.02			0		5.02
5.03			0		5.03
Provider to Program					
5.50			0		5.50
5.51			0		5.51
5.52			0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		126,327		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		368,137		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00