

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: 14-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/21/2021 10:25 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/21/2021	Time: 10:25 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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by KIRBY HOSPITAL (14-1301) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) KIMBERLY ALVIS

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-30,788	-487,226	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	-327,789	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		28,817		0	10.00
10.01	RURAL HEALTH CLINIC II	0		175,779		0	10.01
10.02	RURAL HEALTH CLINIC III	0		9,240		0	10.02
200.00	Total	0	-358,577	-273,390	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: 14-1301		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/21/2021 10:25 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1000 MEDICAL CENTER DRIVE			PO Box:				1.00		
2.00	City: MONTICELLO			State: IL		Zip Code: 61856		County: PIATT		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		KIRBY HOSPITAL	141301	16580	1	08/08/1999	N	O	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		KIRBY HOSPITAL - SWING BED	14Z301	16580		08/08/1999	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		ATWOOD RURAL HEALTH CLINIC	143438	16580		11/17/1997	N	O	N
15.01	Hospital-Based Health Clinic - RHC I		KIRBY MEDICAL GROUP RHC	143495	16580		11/20/2008	N	O	N
15.02	Hospital-Based Health Clinic - RHC III		CERRO GORDO RURAL HEALTH CLINIC	148566	16580		12/29/2016	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020	06/30/2021		20.00
21.00	Type of Control (see instructions)						2			21.00
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/21/2021 10:25 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		25.00
					Urban/Rural St	Date of Geogra	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		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.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					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	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1301		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/21/2021 10:25 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00
					0.000000	64.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/21/2021 10:25 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						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
70.00	Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
	Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

MCRIF32 - 16.12.172.4

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/21/2021 10:25 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:	112,488	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1301		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/21/2021 10:25 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:						
142.00	Street:	PO Box:								
143.00	City:	State:		Zip Code:						
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.								N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.									146.00
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital	N	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	N	157.00		
158.00	SUBPROVIDER							158.00		
159.00	SNF	N	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	N	161.00		
								1.00		
165.00	Multicampus Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00		
								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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/21/2021 10:25 am
			Y/N 1.00	Date 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 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	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 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 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	09/30/2021	Y 09/30/2021
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/21/2021 10:25 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		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.		Y		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.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 14-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/21/2021 10:25 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.	DIRECTOR, REIMBURSEMENT		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: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/21/2021 10:25 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	16	5,840	5,304.00	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)		16	5,840	5,304.00	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)		16	5,840	5,304.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		16				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: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/21/2021 10:25 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)	108	6	228			1.00
2.00	HMO and other (see instructions)	73	0				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	618	0	1,396			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	286			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	726	6	1,910			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)	726	6	1,910	0.00	205.03	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	412	0	2,508	0.00	5.34	26.00
26.01	RURAL HEALTH CLINIC II	2,551	0	15,776	0.00	39.76	26.01
26.02	RURAL HEALTH CLINIC III	496	0	3,013	0.00	7.66	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	257.79	27.00
28.00	Observation Bed Days		0	261			28.00
29.00	Ambulance Trips	438					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: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/21/2021 10:25 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	30	2	65	1.00
2.00 HMO and other (see instructions)			26	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	30	2	65	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RURAL HEALTH CLINIC III	0.00					26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1301		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8	
Component CCN: 14-3438		Date/Time Prepared: 11/21/2021 10:25 am			
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street		108 SOUTH MAIN STREET		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		ATWOOD IL 61913		2.00
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0		3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N 0		10.00
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		2.00	
Facility hours of operations (1)					
11.00	CLINIC		08:00	16:30	08:00
		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.		N 0		13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
		County		4.00	
2.00	City, State, ZIP Code, County		DOUGLAS		2.00
		Tuesday	Wednesday		Thursday
		to	from	to	from
		6.00	7.00	8.00	9.00
		Facility hours of operations (1)		to	
11.00	CLINIC	16:30	08:00	16:30	08:00
		16:30		16:30	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1301

Period:

Worksheet S-8

Component CCN: 14-3438

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/21/2021 10:25 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:00	16:30				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1301		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8	
Component CCN: 14-3495		Date/Time Prepared: 11/21/2021 10:25 am			
		RHC II		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street		1000 MEDICAL CENTER DRIVE		1.00
	City		State	ZIP Code	
	1.00		2.00	3.00	
2.00	City, State, ZIP Code, County		MONTICELLO IL 61856		2.00
					1.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00
			Grant Award		Date
			1.00		2.00
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
					1.00 2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N 0 10.00
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC		07:00	18:00	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.				N 0 13.00
			Provider name		CCN number
			1.00		2.00
14.00	RHC/FQHC name, CCN number				
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
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)				5.00 15.00
			County		
			4.00		
2.00	City, State, ZIP Code, County		PIATT 2.00		
		Tuesday	Wednesday		Thursday
		to	from	to	from to
		6.00	7.00	8.00	9.00 10.00
Facility hours of operations (1)					
11.00	CLINIC	18:00	07:00	18:00	07:00 18:00 11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1301

Period:

Worksheet S-8

Component CCN: 14-3495

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/21/2021 10:25 am

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)						
	CLINIC	07:00	16:00	08:00	12:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1301				Period: From 07/01/2020 To 06/30/2021		Worksheet S-8	
Component CCN: 14-8566				Date/Time Prepared: 11/21/2021 10:25 am			
				RHC III		Cost	
				1.00			
1.00	Clinic Address and Identification Street			407 S. JACKSON STREET, SUITE A		1.00	
				City		State	
				1.00		2.00	
2.00	City, State, ZIP Code, County			CERRO GORDO		IL 61818	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0	
				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	
				Sunday		Monday	
				from		to	
				1.00		2.00	
				from		to	
				3.00		4.00	
				from		to	
				5.00		6.00	
Facility hours of operations (1)							
11.00	CLINIC			07:00		17:30	
				17:30		07:00	
				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.			N		0	
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00	
				Y/N		V	
				1.00		2.00	
				XVIII		XIX	
				3.00		4.00	
				Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
				County			
				4.00			
2.00	City, State, ZIP Code, County			PIATT		2.00	
				Tuesday		Wednesday	
				to		to	
				6.00		7.00	
				8.00		9.00	
				10.00		11.00	
Facility hours of operations (1)							
11.00	CLINIC			16:30		08:00	
				17:30		08:00	
				16:30		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1301

Period:

Worksheet S-8

Component CCN: 14-8566

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/21/2021 10:25 am

RHC III

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/21/2021 10:25 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)		0.403693		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		4,175,429		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		12,046,846		6.00
7.00	Medicaid cost (line 1 times line 6)		4,863,227		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)		687,798		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		300,000		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		687,798		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,366,907	0	1,366,907	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	551,811	0	551,811	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	551,811	0	551,811	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,317,060		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		223,399		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		343,691		27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,973,369		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		916,927		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,468,738		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,156,536		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-1301		Period: From 07/01/2020 To 06/30/2021		Worksheet A Date/Time Prepared: 11/21/2021 10:25 am	
		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)		
			1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS									
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,323,394	4,323,394	-35,123	4,288,271	1.00	
1.01	00101	RURAL HEALTH CLINIC I BUILDING		0	0	18,697	18,697	1.01	
1.02	00102	RURAL HEALTH CLINIC III BUILDING		0	0	93,205	93,205	1.02	
1.03	00103	CROSSFIT BUILDING		0	0	60,385	60,385	1.03	
1.04	00104	AMBULANCE/MAINTENANCE GARAGE		0	0	14,607	14,607	1.04	
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,741,432	1,741,432	40,290	1,781,722	2.00	
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	85,808	243,150	328,958	60,421	389,379	4.00	
5.01	00540	PFS & REGISTRATION	563,356	556,794	1,120,150	618,558	1,738,708	5.01	
5.02	00550	ADMINISTRATIVE & GENERAL	2,915,322	5,287,648	8,202,970	-831,475	7,371,495	5.02	
6.00	00600	MAINTENANCE & REPAIRS	337,529	454,887	792,416	0	792,416	6.00	
7.00	00700	OPERATION OF PLANT	0	414,237	414,237	-159,145	255,092	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	52,431	52,431	8.00	
9.00	00900	HOUSEKEEPING	351,355	196,581	547,936	-28,700	519,236	9.00	
10.00	01000	DIETARY	536,797	396,965	933,762	-769,840	163,922	10.00	
11.00	01100	CAFETERIA	0	0	0	732,332	732,332	11.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	165,680	60,377	226,057	-131	225,926	14.00	
15.00	01500	PHARMACY	182,236	611,182	793,418	-436,093	357,325	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	721,365	430,505	1,151,870	189,605	1,341,475	16.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	378,908	58,077	436,985	0	436,985	19.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	1,371,724	1,293,181	2,664,905	90,490	2,755,395	30.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	648,569	2,172,360	2,820,929	-711,303	2,109,626	50.00	
53.00	05300	ANESTHESIOLOGY	0	740,817	740,817	0	740,817	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	815,488	1,408,308	2,223,796	91,804	2,315,600	54.00	
54.01	03952	ULTRASOUND	0	0	0	0	0	54.01	
60.00	06000	LABORATORY	668,029	1,824,071	2,492,100	87,916	2,580,016	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
66.00	06600	PHYSICAL THERAPY	746,179	298,971	1,045,150	2,015	1,047,165	66.00	
67.00	06700	OCCUPATIONAL THERAPY	181,113	38,475	219,588	0	219,588	67.00	
68.00	06800	SPEECH PATHOLOGY	27,177	3,408	30,585	0	30,585	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	27,639	27,639	14,547	42,186	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	495,975	495,975	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	323,961	323,961	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	458,447	458,447	73.00	
76.00	03950	SLEEP LAB	115,805	84,573	200,378	200	200,578	76.00	
76.01	03951	DIABETIC EDUCATION	0	0	0	10,306	10,306	76.01	
76.02	03020	SENIOR LIFE SOLUTIONS	38,067	437,259	475,326	489	475,815	76.02	
76.03	03030	WOUNDCARE	16,435	142,844	159,279	-2,586	156,693	76.03	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	447,214	213,035	660,249	-62,489	597,760	88.00	
88.01	08801	RURAL HEALTH CLINIC II	3,139,834	1,839,119	4,978,953	-336,501	4,642,452	88.01	
88.02	08802	RURAL HEALTH CLINIC III	460,919	234,300	695,219	-78,816	616,403	88.02	
91.00	09100	EMERGENCY	1,337,329	3,078,117	4,415,446	-86,162	4,329,284	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	410,119	278,278	688,397	96,583	784,980	95.00	
SPECIAL PURPOSE COST CENTERS									
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,662,357	28,889,984	45,552,341	14,900	45,567,241	118.00	
NONREIMBURSABLE COST CENTERS									
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	101,896	101,896	-6,765	95,131	192.00	
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	355,860	1,321,946	1,677,806	-500	1,677,306	194.00	
194.01	07951	FOUNDATION	66,783	310,745	377,528	0	377,528	194.01	
194.02	07952	CROSSFIT	102,672	68,284	170,956	-7,635	163,321	194.02	
200.00		TOTAL (SUM OF LINES 118 through 199)	17,187,672	30,692,855	47,880,527	0	47,880,527	200.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1301

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

Worksheet A

Date/Time Prepared:
11/21/2021 10:25 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-138,701	4,149,570	1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING	0	18,697	1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING	0	93,205	1.02
1.03	00103	CROSSFIT BUILDING	0	60,385	1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE	0	14,607	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,781,722	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-75	389,304	4.00
5.01	00540	PFS & REGISTRATION	0	1,738,708	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	-1,441,924	5,929,571	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	792,416	6.00
7.00	00700	OPERATION OF PLANT	4,831	259,923	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	52,431	8.00
9.00	00900	HOUSEKEEPING	0	519,236	9.00
10.00	01000	DIETARY	0	163,922	10.00
11.00	01100	CAFETERIA	-172,218	560,114	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	225,926	14.00
15.00	01500	PHARMACY	0	357,325	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-266	1,341,209	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-200,892	236,093	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-574,499	2,180,896	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-36,540	2,073,086	50.00
53.00	05300	ANESTHESIOLOGY	-718,055	22,762	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-495,406	1,820,194	54.00
54.01	03952	ULTRASOUND	0	0	54.01
60.00	06000	LABORATORY	-39,099	2,540,917	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	-26,249	1,020,916	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	219,588	67.00
68.00	06800	SPEECH PATHOLOGY	0	30,585	68.00
69.00	06900	ELECTROCARDIOLOGY	-23,475	18,711	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	495,975	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	323,961	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	458,447	73.00
76.00	03950	SLEEP LAB	-36,451	164,127	76.00
76.01	03951	DIABETIC EDUCATION	0	10,306	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	475,815	76.02
76.03	03030	WOUNDCARE	0	156,693	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	597,760	88.00
88.01	08801	RURAL HEALTH CLINIC II	-300,297	4,342,155	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	616,403	88.02
91.00	09100	EMERGENCY	-1,249,171	3,080,113	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-58,874	726,106	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,507,361	40,059,880	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	95,131	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	-42,681	1,634,625	194.00
194.01	07951	FOUNDATION	0	377,528	194.01
194.02	07952	CROSSFIT	0	163,321	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,550,042	42,330,485	200.00

RECLASSIFICATIONS

Provider CCN: 14-1301

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

Worksheet A-6

Date/Time Prepared:
11/21/2021 10:25 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	93,146		1.00
	0		0	93,146		
	C - CAFETERIA					
1.00	CAFETERIA	11.00	419,300	313,032		1.00
2.00	DIABETIC EDUCATION	76.01	7,787	2,489		2.00
3.00	RURAL HEALTH CLINIC II	88.01	1,080	345		3.00
	0		428,167	315,866		
	D - EKG					
1.00	ELECTROCARDIOLOGY	69.00	11,161	3,386		1.00
2.00		0.00	0	0		2.00
	0		11,161	3,386		
	E - RHC ADMITTING					
1.00	PFS & REGISTRATION	5.01	458,354	126,108		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	3,025	776		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		461,379	126,884		
	F - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	52,431		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
	0		0	52,431		
	G - CROSSFIT EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	4,467	2,962		1.00
	0		4,467	2,962		
	H - WORKERS' COMP INS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	52,992		1.00
	0		0	52,992		
	I - TELEPHONE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.02	0	170,363		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	0		0	170,363		
	J - DOCTORS BLDG COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.02	0	1,372		1.00
2.00	OPERATION OF PLANT	7.00	0	2,496		2.00
	0		0	3,868		
	K - MEDICAL SUPPLIES, IMPLANTS & DRUGS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	471,880		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	323,961		2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	436,093		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	0		0	1,231,934		
	L - AMBULANCE SALARY					
1.00	AMBULANCE SERVICES	95.00	78,963	22,846		1.00
	0		78,963	22,846		
	N - DEPRECIATION EXPENSE RECLASS					
1.00	RURAL HEALTH CLINIC I BUILDING	1.01	0	18,281		1.00
2.00	RURAL HEALTH CLINIC III BUILDING	1.02	0	91,085		2.00
3.00	CROSSFIT BUILDING	1.03	0	58,011		3.00
4.00	AMBULANCE/MAINTENANCE GARAGE	1.04	0	14,100		4.00
	0		0	181,477		
	O - BOND RELATED COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	98,915		1.00
	0		0	98,915		

RECLASSIFICATIONS

Provider CCN: 14-1301

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

Worksheet A-6

Date/Time Prepared:
11/21/2021 10:25 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
S - MOB EXPENSE					
1.00	PFS & REGISTRATION	5.01	0	10,001	1.00
2.00	ADMINISTRATIVE & GENERAL	5.02	0	7,242	2.00
	TOTALS		0	17,243	
T - WOUND CARE IN MOB					
1.00	WOUNDCARE	76.03	0	2,566	1.00
	TOTALS		0	2,566	
U - CLINIC CONTRACT HOUSEKEEPING					
1.00	RURAL HEALTH CLINIC	88.00	0	11,900	1.00
2.00	RURAL HEALTH CLINIC III	88.02	0	16,800	2.00
	TOTALS		0	28,700	
V - DIETICIANS IN A&P					
1.00	ADULTS & PEDIATRICS	30.00	18,023	5,761	1.00
	TOTALS		18,023	5,761	
W - IT AND CLINICAL INFORMATICS					
1.00	PFS & REGISTRATION	5.01	0	24,095	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	206,848	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	105,917	3.00
4.00	OPERATING ROOM	50.00	0	35,957	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	101,159	5.00
6.00	LABORATORY	60.00	0	87,916	6.00
7.00	PHYSICAL THERAPY	66.00	0	4,338	7.00
8.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	24,095	8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	22,354	9.00
10.00	SLEEP LAB	76.00	0	635	10.00
11.00	DIABETIC EDUCATION	76.01	0	30	11.00
12.00	SENIOR LIFE SOLUTIONS	76.02	0	489	12.00
13.00	WOUNDCARE	76.03	0	369	13.00
14.00	RURAL HEALTH CLINIC	88.00	0	9,572	14.00
15.00	RURAL HEALTH CLINIC II	88.01	0	58,759	15.00
16.00	RURAL HEALTH CLINIC III	88.02	0	10,845	16.00
17.00	EMERGENCY	91.00	0	70,198	17.00
18.00	AMBULANCE SERVICES	95.00	0	1,823	18.00
	TOTALS		0	765,399	
500.00	Grand Total: Increases		1,002,160	3,176,739	500.00

RECLASSIFICATIONS

Provider CCN: 14-1301

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

Worksheet A-6

Date/Time Prepared:
11/21/2021 10:25 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.02	0	93,146	12		1.00
	0		0	93,146			
	C - CAFETERIA						
1.00	DIETARY	10.00	428,167	315,866	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		428,167	315,866			
	D - EKG						
1.00	EMERGENCY	91.00	8,169	2,364	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	2,992	1,022	0		2.00
	0		11,161	3,386			
	E - RHC ADMITTING						
1.00	RURAL HEALTH CLINIC	88.00	60,763	19,819	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	315,466	80,944	0		2.00
3.00	RURAL HEALTH CLINIC III	88.02	81,109	24,641	0		3.00
4.00	WOUNDCARE	76.03	4,041	1,480	0		4.00
	0		461,379	126,884			
	F - LAUNDRY						
1.00	DIETARY	10.00	0	2,023	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	19,864	0		2.00
3.00	OPERATING ROOM	50.00	0	10,806	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,341	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	2,323	0		5.00
6.00	SLEEP LAB	76.00	0	435	0		6.00
7.00	RURAL HEALTH CLINIC II	88.01	0	275	0		7.00
8.00	EMERGENCY	91.00	0	11,056	0		8.00
9.00	AMBULANCE SERVICES	95.00	0	102	0		9.00
10.00	CROSSFIT	194.02	0	206	0		10.00
	0		0	52,431			
	G - CROSSFIT EMPLOYEE BENEFITS						
1.00	CROSSFIT	194.02	4,467	2,962	0		1.00
	0		4,467	2,962			
	H - WORKERS' COMP INS						
1.00	ADMINISTRATIVE & GENERAL	5.02	0	52,992	0		1.00
	0		0	52,992			
	I - TELEPHONE EXPENSE						
1.00	RURAL HEALTH CLINIC	88.00	0	3,379	0		1.00
2.00	OPERATION OF PLANT	7.00	0	157,773	0		2.00
3.00	RURAL HEALTH CLINIC III	88.02	0	711	0		3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	8,000	0		4.00
5.00	RETAIL PHARMACIES - KIRBY & CERRO	194.00	0	500	0		5.00
	0		0	170,363			
	J - DOCTORS BLDG COSTS						
1.00	OPERATION OF PLANT	7.00	0	3,868	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	3,868			
	K - MEDICAL SUPPLIES, IMPLANTS & DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	131	0		1.00
2.00	PHARMACY	15.00	0	436,093	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	19,347	0		3.00
4.00	OPERATING ROOM	50.00	0	736,454	0		4.00
5.00	EMERGENCY	91.00	0	32,962	0		5.00
6.00	AMBULANCE SERVICES	95.00	0	6,947	0		6.00
	0		0	1,231,934			
	L - AMBULANCE SALARY						
1.00	EMERGENCY	91.00	78,963	22,846	0		1.00
	0		78,963	22,846			
	N - DEPRECIATION EXPENSE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	181,477	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
4.00		0.00	0	0	9		4.00
	0		0	181,477			
	O - BOND RELATED COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.02	0	98,915	14		1.00
	0		0	98,915			
	S - MOB EXPENSE						
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	17,243	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	17,243			

RECLASSIFICATIONS

Provider CCN: 14-1301

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

Worksheet A-6

Date/Time Prepared:
11/21/2021 10:25 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
T - WOUND CARE IN MOB						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,566	0	1.00
	TOTALS		0	2,566		
U - CLINIC CONTRACT HOUSEKEEPING						
1.00	HOUSEKEEPING	9.00	0	28,700	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	28,700		
V - DIETICIANS IN A&P						
1.00	DIETARY	10.00	18,023	5,761	0	1.00
	TOTALS		18,023	5,761		
W - IT AND CLINICAL INFORMATICS						
1.00	ADMINISTRATIVE & GENERAL	5.02	0	765,399	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
	TOTALS		0	765,399		
500.00	Grand Total: Decreases		1,002,160	3,176,739		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/21/2021 10:25 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	389,780	0	0	0	0	1.00	
2.00	Land Improvements	6,437,157	45,955	0	45,955	0	2.00	
3.00	Buildings and Fixtures	28,458,132	1,214,788	0	1,214,788	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	109,916	100,644	0	100,644	0	5.00	
6.00	Movable Equipment	15,273,837	360,085	0	360,085	0	6.00	
7.00	HIT designated Assets	11,500,219	968,908	0	968,908	84,823	7.00	
8.00	Subtotal (sum of lines 1-7)	62,169,041	2,690,380	0	2,690,380	84,823	8.00	
9.00	Reconciling Items	-381,254	-1,151,192	0	-1,151,192	0	9.00	
10.00	Total (line 8 minus line 9)	62,550,295	3,841,572	0	3,841,572	84,823	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	389,780	0					1.00
2.00	Land Improvements	6,483,112	0					2.00
3.00	Buildings and Fixtures	29,672,920	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	210,560	0					5.00
6.00	Movable Equipment	15,633,922	0					6.00
7.00	HIT designated Assets	12,384,304	0					7.00
8.00	Subtotal (sum of lines 1-7)	64,774,598	0					8.00
9.00	Reconciling Items	-1,532,446	0					9.00
10.00	Total (line 8 minus line 9)	66,307,044	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/21/2021 10:25 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,704,484	0	1,618,910	0	0	1.00
1.01	RURAL HEALTH CLINIC I BUILDING	0	0	0	0	0	1.01
1.02	RURAL HEALTH CLINIC III BUILDING	0	0	0	0	0	1.02
1.03	CROSSFIT BUILDING	0	0	0	0	0	1.03
1.04	AMBULANCE/MAINTENANCE GARAGE	0	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	1,741,432	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,445,916	0	1,618,910	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	4,323,394				1.00
1.01	RURAL HEALTH CLINIC I BUILDING	0	0				1.01
1.02	RURAL HEALTH CLINIC III BUILDING	0	0				1.02
1.03	CROSSFIT BUILDING	0	0				1.03
1.04	AMBULANCE/MAINTENANCE GARAGE	0	0				1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,741,432				2.00
3.00	Total (sum of lines 1-2)	0	6,064,826				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/21/2021 10:25 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	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	32,989,720	0	32,989,720	0.509299	47,439	1.00
1.01	RURAL HEALTH CLINIC I BUILDING	289,068	0	289,068	0.004463	416	1.01
1.02	RURAL HEALTH CLINIC III BUILDING	1,474,468	0	1,474,468	0.022763	2,120	1.02
1.03	CROSSFIT BUILDING	1,650,620	0	1,650,620	0.025483	2,374	1.03
1.04	AMBULANCE/MAINTENANCE GARAGE	352,496	0	352,496	0.005442	507	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	28,018,226	0	28,018,226	0.432550	40,290	2.00
3.00	Total (sum of lines 1-2)	64,774,598	0	64,774,598	0.000000	93,146	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	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	47,439	2,469,723	0	1.00
1.01	RURAL HEALTH CLINIC I BUILDING	0	0	416	18,281	0	1.01
1.02	RURAL HEALTH CLINIC III BUILDING	0	0	2,120	91,085	0	1.02
1.03	CROSSFIT BUILDING	0	0	2,374	58,011	0	1.03
1.04	AMBULANCE/MAINTENANCE GARAGE	0	0	507	14,100	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	40,290	1,741,432	0	2.00
3.00	Total (sum of lines 1-2)	0	0	93,146	4,392,632	0	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)	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,533,493	47,439	0	98,915	4,149,570	1.00
1.01	RURAL HEALTH CLINIC I BUILDING	0	416	0	0	18,697	1.01
1.02	RURAL HEALTH CLINIC III BUILDING	0	2,120	0	0	93,205	1.02
1.03	CROSSFIT BUILDING	0	2,374	0	0	60,385	1.03
1.04	AMBULANCE/MAINTENANCE GARAGE	0	507	0	0	14,607	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	40,290	0	0	1,781,722	2.00
3.00	Total (sum of lines 1-2)	1,533,493	93,146	0	98,915	6,118,186	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1301

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

Worksheet A-8

Date/Time Prepared:
11/21/2021 10:25 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-85,417	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - RURAL HEALTH CLINIC I BUILDING (chapter 2)			0 RURAL HEALTH CLINIC I BUILDING	1.01	0	1.01
1.02	Investment income - RURAL HEALTH CLINIC III BUILDING (chapter 2)			0 RURAL HEALTH CLINIC III BUILDING	1.02	0	1.02
1.03	Investment income - CROSSFIT BUILDING (chapter 2)			0 CROSSFIT BUILDING	1.03	0	1.03
1.04	Investment income - AMBULANCE/MAINTENANCE GARAGE (chapter 2)			0 AMBULANCE/MAINTENANCE GARAGE	1.04	0	1.04
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0 CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,606	ADMINISTRATIVE & GENERAL	5.02	0	7.00
8.00	Television and radio service (chapter 21)			0	0.00	0	8.00
9.00	Parking lot (chapter 21)			0	0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,172,903			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	-172,218	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00	Sale of drugs to other than patients			0	0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3	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 - CAP REL COSTS-BLDG & FIXT			0 CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - RURAL HEALTH CLINIC I BUILDING			0 RURAL HEALTH CLINIC I BUILDING	1.01	0	26.01
26.02	Depreciation - RURAL HEALTH CLINIC III BUILDING			0 RURAL HEALTH CLINIC III BUILDING	1.02	0	26.02
26.03	Depreciation - CROSSFIT BUILDING			0 CROSSFIT BUILDING	1.03	0	26.03

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1301

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

Worksheet A-8

Date/Time Prepared:
11/21/2021 10:25 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	
26.04	Depreciation - AMBULANCE/MAINTENANCE GARAGE			0 AMBULANCE/MAINTENANCE GARAGE	1.04	0	26.04
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0 CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-200,892	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0 OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0 ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0 SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-69,063	ADMINISTRATIVE & GENERAL	5.02	0	33.00
33.01	AMBULANCE INCOME	B	-58,874	AMBULANCE SERVICES	95.00	0	33.01
33.02	CANCER CLINIC INCOME	B	-5,527	ADMINISTRATIVE & GENERAL	5.02	0	33.02
33.03	PHASE III CARDIAC REHAB INCOME	B	-25,975	PHYSICAL THERAPY	66.00	0	33.03
33.04	NON-ALLOWABLE ADVERTISING	A	-337,944	ADMINISTRATIVE & GENERAL	5.02	0	33.04
33.05	NON-ALLOWABLE LOBBYING	A	-11,840	ADMINISTRATIVE & GENERAL	5.02	0	33.05
33.06	PROPERTY TAX	A	-4,517	ADMINISTRATIVE & GENERAL	5.02	0	33.06
33.07	MEDICAID ASSESSMENT TAX	A	-911,092	ADMINISTRATIVE & GENERAL	5.02	0	33.07
33.08	KEY EMPLOYEE LIFE INSURANCE	A	-18,011	ADMINISTRATIVE & GENERAL	5.02	0	33.08
33.09	TRUST DEPR HOSPITAL ADMINISTRATION	A	2,658	ADMINISTRATIVE & GENERAL	5.02	0	33.09
33.10	TRUST DEPR OPERATION OF PLANT	A	4,831	OPERATION OF PLANT	7.00	0	33.10
33.12	TIF EXPENSE NOT RELATED TO THE HOSPI	A	-17,276	ADMINISTRATIVE & GENERAL	5.02	0	33.12
33.14	NON-ALLOWABLE DONATION EXPENSE	A	-67,620	ADMINISTRATIVE & GENERAL	5.02	0	33.14
34.00	MISC EXPENSE - A&G	A	-86	ADMINISTRATIVE & GENERAL	5.02	0	34.00
34.01	MISC EXPENSE - EMPLOYEE BENEFITS	A	-75	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.01
34.04	MISC EXPENSE - MED RECORDS	A	-263	MEDICAL RECORDS & LIBRARY	16.00	0	34.04
34.05	MISC EXPENSE - PT	A	-47	PHYSICAL THERAPY	66.00	0	34.05
34.06	MISC EXPENSE - ANESTHESIA	A	-20	ANESTHESIOLOGY	53.00	0	34.06
34.07	MISC EXPENSE - RHC II	A	-403	RURAL HEALTH CLINIC II	88.01	0	34.07
35.00	WELLNESS TRAIL DEPRECIATION EXPENSE	A	-53,284	CAP REL COSTS-BLDG & FIXT	1.00	9	35.00
36.00	KMH RHC PROFESSIONAL FEES	A	-299,894	RURAL HEALTH CLINIC II	88.01	0	36.00
37.00	GOODWILL AMORTIZATION	A	-42,681	RETAIL PHARMACIES - KIRBY & CERRO	194.00	0	37.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,550,042				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: 14-1301

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

Worksheet A-8-2

Date/Time Prepared:
11/21/2021 10:25 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	30.00	ADULTS & PEDIATRICS	574,499	574,499	0	0	0	1.00
2.00	50.00	OPERATING ROOM	36,540	36,540	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	718,035	718,035	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	495,406	495,406	0	0	0	4.00
5.00	60.00	LABORATORY	39,099	39,099	0	0	0	5.00
6.00	66.00	PHYSICAL THERAPY	227	227	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	23,475	23,475	0	0	0	7.00
8.00	76.00	SLEEP LAB	36,451	36,451	0	0	0	8.00
9.00	91.00	EMERGENCY	2,517,309	1,249,171	1,268,138	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,441,041	3,172,903	1,268,138		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	76.00	SLEEP LAB	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	574,499		1.00
2.00	50.00	OPERATING ROOM	0	0	0	36,540		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	718,035		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	495,406		4.00
5.00	60.00	LABORATORY	0	0	0	39,099		5.00
6.00	66.00	PHYSICAL THERAPY	0	0	0	227		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	23,475		7.00
8.00	76.00	SLEEP LAB	0	0	0	36,451		8.00
9.00	91.00	EMERGENCY	0	0	0	1,249,171		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,172,903		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/21/2021 10:25 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			BLDG & FIXT	RURAL HEALTH CLINIC I BUILDING	RURAL HEALTH CLINIC III BUILDING	CROSSFIT BUILDING	
		0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,149,570	4,149,570			1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING	18,697	0	18,697		1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING	93,205	0	0	93,205	1.02
1.03	00103	CROSSFIT BUILDING	60,385	0	0	0	1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE	14,607	0	0	0	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,781,722				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	389,304	5,383	0	0	4.00
5.01	00540	PFS & REGISTRATION	1,738,708	73,792	0	0	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	5,929,571	310,374	0	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	792,416	12,752	0	0	6.00
7.00	00700	OPERATION OF PLANT	259,923	877,659	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	52,431	16,096	0	0	8.00
9.00	00900	HOUSEKEEPING	519,236	41,704	0	0	9.00
10.00	01000	DIETARY	163,922	127,620	0	0	10.00
11.00	01100	CAFETERIA	560,114	58,897	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	225,926	85,550	0	0	14.00
15.00	01500	PHARMACY	357,325	29,632	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,341,209	46,041	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	236,093	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,180,896	471,022	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,073,086	405,696	0	0	50.00
53.00	05300	ANESTHESIOLOGY	22,762	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,820,194	199,477	0	0	54.00
54.01	03952	ULTRASOUND	0	0	0	0	54.01
60.00	06000	LABORATORY	2,540,917	121,975	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,020,916	221,949	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	219,588	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	30,585	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	18,711	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	495,975	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	323,961	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	458,447	0	0	0	73.00
76.00	03950	SLEEP LAB	164,127	17,559	0	0	76.00
76.01	03951	DIABETIC EDUCATION	10,306	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	475,815	0	0	0	76.02
76.03	03030	WOUND CARE	156,693	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	597,760	0	18,697	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,342,155	617,664	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	616,403	0	0	75,430	88.02
91.00	09100	EMERGENCY	3,080,113	334,832	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	726,106	40,188	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,059,880	4,115,862	18,697	75,430	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,776	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	95,131	0	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	1,634,625	11,915	0	17,775	194.00
194.01	07951	FOUNDATION	377,528	5,017	0	0	194.01
194.02	07952	CROSSFIT	163,321	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	42,330,485	4,149,570	18,697	93,205	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/21/2021 10:25 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	PFS & REGISTRATION	Subtotal	
			AMBULANCE/MAIN TENANCE GARAGE	MVBLE EQUIP				
			1.04	2.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE	14,607					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,781,722				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	394,687			4.00
5.01	00540	PFS & REGISTRATION	0	0	23,842	1,836,342		5.01
5.02	00550	ADMINISTRATIVE & GENERAL	0	598,319	68,025	0	6,906,289	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	18,069	7,876	0	831,113	6.00
7.00	00700	OPERATION OF PLANT	7,430	129,599	0	0	1,274,611	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	68,527	8.00
9.00	00900	HOUSEKEEPING	135	9,178	8,199	0	578,452	9.00
10.00	01000	DIETARY	0	40,570	2,114	0	334,226	10.00
11.00	01100	CAFETERIA	0	0	9,784	0	628,795	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,108	3,866	0	318,450	14.00
15.00	01500	PHARMACY	0	39,201	4,252	0	430,410	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,960	16,833	0	1,421,043	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	4,567	0	240,660	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	90,882	32,430	173,929	2,949,159	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	172,362	15,134	286,906	2,953,184	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	55,801	78,563	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	388,603	18,960	295,278	2,722,512	54.00
54.01	03952	ULTRASOUND	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	65,678	15,588	355,284	3,099,442	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	5,374	17,412	88,305	1,353,956	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	4,226	23,910	247,724	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	634	3,618	34,837	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	260	17,438	36,409	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	21,257	517,232	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	13,913	337,874	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	96,133	554,580	73.00
76.00	03950	SLEEP LAB	0	2,048	2,702	12,410	198,846	76.00
76.01	03951	DIABETIC EDUCATION	0	0	182	816	11,304	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	0	888	13,076	489,779	76.02
76.03	03030	WOUNDCARE	0	0	289	8,017	164,999	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	5,295	9,018	13,637	644,407	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	32,141	65,932	86,618	5,144,510	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	17,843	8,863	14,913	733,452	88.02
91.00	09100	EMERGENCY	0	22,290	29,173	206,899	3,673,307	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	7,042	78,948	11,413	48,184	911,881	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,607	1,736,468	382,462	1,836,342	39,890,533	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	16,776	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	21,658	71	0	116,860	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	0	15,239	8,304	0	1,687,858	194.00
194.01	07951	FOUNDATION	0	0	1,558	0	384,103	194.01
194.02	07952	CROSSFIT	0	8,357	2,292	0	234,355	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,607	1,781,722	394,687	1,836,342	42,330,485	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/21/2021 10:25 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.02	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	PFS & REGISTRATION						5.01
5.02	00550	ADMINISTRATIVE & GENERAL	6,906,289					5.02
6.00	00600	MAINTENANCE & REPAIRS	162,034	993,147				6.00
7.00	00700	OPERATION OF PLANT	248,498	234,608	1,757,717			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,360	3,750	9,859	95,496		8.00
9.00	00900	HOUSEKEEPING	112,775	10,264	25,545	0	727,036	9.00
10.00	01000	DIETARY	65,161	29,733	78,171	3,684	33,196	10.00
11.00	01100	CAFETERIA	122,590	13,722	36,076	0	15,320	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	62,085	19,931	52,402	0	22,253	14.00
15.00	01500	PHARMACY	83,913	6,904	18,150	0	7,708	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	277,047	10,727	28,202	0	11,976	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	46,919	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	574,968	109,738	288,514	36,205	122,521	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	575,753	94,519	248,500	19,669	105,528	50.00
53.00	05300	ANESTHESIOLOGY	15,317	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	530,781	46,474	122,185	9,726	51,887	54.00
54.01	03952	ULTRASOUND	0	0	0	0	0	54.01
60.00	06000	LABORATORY	604,267	28,418	74,713	0	31,728	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	263,967	51,710	135,950	4,232	57,733	66.00
67.00	06700	OCCUPATIONAL THERAPY	48,296	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,792	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,098	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	100,840	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,872	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	108,121	0	0	0	0	73.00
76.00	03950	SLEEP LAB	38,767	4,091	10,756	790	4,568	76.00
76.01	03951	DIABETIC EDUCATION	2,204	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	95,487	0	0	0	0	76.02
76.03	03030	WOUND CARE	32,168	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	125,634	7,537	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,002,959	143,903	378,338	499	160,665	88.01
88.02	08802	RURAL HEALTH CLINIC III	142,994	0	0	0	0	88.02
91.00	09100	EMERGENCY	716,148	78,009	205,094	20,130	87,095	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	177,780	37,927	24,616	187	10,454	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,430,595	931,965	1,737,071	95,122	722,632	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,271	3,908	10,275	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,783	0	0	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	329,065	2,776	7,298	0	3,099	194.00
194.01	07951	FOUNDATION	74,885	1,169	3,073	0	1,305	194.01
194.02	07952	CROSSFIT	45,690	53,329	0	374	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,906,289	993,147	1,757,717	95,496	727,036	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	PFS & REGISTRATION						5.01
5.02	00550	ADMINISTRATIVE & GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	544,171					10.00
11.00	01100	CAFETERIA	0	816,503				11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23,592	498,713			14.00
15.00	01500	PHARMACY	0	10,151	1,746	558,982		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	81,762	1,830	0	1,832,587	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	544,171	124,149	12,021	0	273,761	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	58,226	27,319	0	168,031	50.00
53.00	05300	ANESTHESIOLOGY	0	6,972	2,586	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	66,536	13,706	0	40,863	54.00
54.01	03952	ULTRASOUND	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	67,484	156,098	0	236,563	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	60,680	2,989	0	52,590	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,378	0	0	7,696	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,785	0	0	1,283	68.00
69.00	06900	ELECTROCARDIOLOGY	0	892	0	0	366	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	113,703	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	78,061	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	558,982	0	73.00
76.00	03950	SLEEP LAB	0	8,645	1,186	0	7,146	76.00
76.01	03951	DIABETIC EDUCATION	0	613	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	5,633	174	0	733	76.02
76.03	03030	WOUNDCARE	0	1,673	0	0	17,408	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	8,797	0	87,039	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	164,637	43,536	0	456,086	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	11,959	0	87,406	88.02
91.00	09100	EMERGENCY	0	101,115	12,780	0	374,910	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	2,117	0	20,706	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	544,171	795,923	490,608	558,982	1,832,587	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	299	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	0	7,752	6,080	0	0	194.00
194.01	07951	FOUNDATION	0	3,514	46	0	0	194.01
194.02	07952	CROSSFIT	0	9,314	1,680	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	544,171	816,503	498,713	558,982	1,832,587	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING					1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING					1.02
1.03	00103	CROSSFIT BUILDING					1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	PFS & REGISTRATION					5.01
5.02	00550	ADMINISTRATIVE & GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	287,579				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	5,035,207	-147,610	4,887,597	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	4,250,729	0	4,250,729	50.00
53.00	05300	ANESTHESIOLOGY	287,579	391,017	0	391,017	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,604,670	0	3,604,670	54.00
54.01	03952	ULTRASOUND	0	0	0	0	54.01
60.00	06000	LABORATORY	0	4,298,713	0	4,298,713	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	147,610	147,610	64.00
66.00	06600	PHYSICAL THERAPY	0	1,983,807	0	1,983,807	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	315,094	0	315,094	67.00
68.00	06800	SPEECH PATHOLOGY	0	44,697	0	44,697	68.00
69.00	06900	ELECTROCARDIOLOGY	0	44,765	0	44,765	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	731,775	0	731,775	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	481,807	0	481,807	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,221,683	0	1,221,683	73.00
76.00	03950	SLEEP LAB	0	274,795	0	274,795	76.00
76.01	03951	DIABETIC EDUCATION	0	14,121	0	14,121	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	591,806	0	591,806	76.02
76.03	03030	WOUNDCARE	0	216,248	0	216,248	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	873,414	0	873,414	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	7,495,133	0	7,495,133	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	975,811	0	975,811	88.02
91.00	09100	EMERGENCY	0	5,268,588	0	5,268,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	1,185,668	0	1,185,668	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	287,579	39,299,548	0	39,299,548	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34,230	0	34,230	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	139,942	0	139,942	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	0	2,043,928	0	2,043,928	194.00
194.01	07951	FOUNDATION	0	468,095	0	468,095	194.01
194.02	07952	CROSSFIT	0	344,742	0	344,742	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	287,579	42,330,485	0	42,330,485	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1301

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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			BLDG & FIXT	RURAL HEALTH CLINIC I BUILDING	RURAL HEALTH CLINIC III BUILDING	CROSSFIT BUILDING	
		0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING					1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING					1.02
1.03	00103	CROSSFIT BUILDING					1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,383	0	0	4.00
5.01	00540	PFS & REGISTRATION	0	73,792	0	0	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	38,283	310,374	0	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	12,752	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,831	877,659	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,096	0	0	8.00
9.00	00900	HOUSEKEEPING	0	41,704	0	0	9.00
10.00	01000	DIETARY	0	127,620	0	0	10.00
11.00	01100	CAFETERIA	0	58,897	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	85,550	0	0	14.00
15.00	01500	PHARMACY	0	29,632	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29,466	46,041	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,098	471,022	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	131,064	405,696	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	170,523	199,477	0	0	54.00
54.01	03952	ULTRASOUND	0	0	0	0	54.01
60.00	06000	LABORATORY	0	121,975	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	221,949	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	SLEEP LAB	1,219	17,559	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	24,682	0	0	0	76.02
76.03	03030	WOUND CARE	1,571	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	18,697	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	617,664	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	75,430	88.02
91.00	09100	EMERGENCY	0	334,832	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	40,188	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	405,737	4,115,862	18,697	75,430	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,776	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	82,916	0	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	24,000	11,915	0	17,775	194.00
194.01	07951	FOUNDATION	0	5,017	0	0	194.01
194.02	07952	CROSSFIT	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	512,653	4,149,570	18,697	93,205	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1301

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	PFS & REGISTRATION	
			AMBULANCE/MAIN TENANCE GARAGE	MVBLE EQUIP				
			1.04	2.00				
GENERAL SERVICE COST CENTERS			1.04	2.00	2A	4.00	5.01	
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	5,383	5,383		4.00
5.01	00540	PFS & REGISTRATION	0	0	73,792	325	74,117	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	0	598,319	946,976	932	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	18,069	30,821	107	0	6.00
7.00	00700	OPERATION OF PLANT	7,430	129,599	1,019,519	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	16,096	0	0	8.00
9.00	00900	HOUSEKEEPING	135	9,178	51,017	112	0	9.00
10.00	01000	DIETARY	0	40,570	168,190	29	0	10.00
11.00	01100	CAFETERIA	0	0	58,897	133	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,108	88,658	53	0	14.00
15.00	01500	PHARMACY	0	39,201	68,833	58	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,960	92,467	229	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	62	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	90,882	566,002	442	7,017	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	172,362	709,122	206	11,575	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,251	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	388,603	758,603	258	11,913	54.00
54.01	03952	ULTRASOUND	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	65,678	187,653	212	14,364	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	5,374	227,323	237	3,563	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	58	965	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	9	146	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4	704	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	858	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	561	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,878	73.00
76.00	03950	SLEEP LAB	0	2,048	20,826	37	501	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	2	33	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	0	24,682	12	528	76.02
76.03	03030	WOUNDCARE	0	0	1,571	4	323	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	5,295	23,992	123	550	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	32,141	649,805	898	3,494	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	17,843	93,273	121	602	88.02
91.00	09100	EMERGENCY	0	22,290	357,122	398	8,347	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	7,042	78,948	126,178	156	1,944	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,607	1,736,468	6,366,801	5,217	74,117	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	16,776	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	21,658	104,574	1	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	0	15,239	68,929	113	0	194.00
194.01	07951	FOUNDATION	0	0	5,017	21	0	194.01
194.02	07952	CROSSFIT	0	8,357	68,742	31	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,607	1,781,722	6,630,839	5,383	74,117	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1301

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.02	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING					1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING					1.02
1.03	00103	CROSSFIT BUILDING					1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	PFS & REGISTRATION					5.01
5.02	00550	ADMINISTRATIVE & GENERAL	947,908				5.02
6.00	00600	MAINTENANCE & REPAIRS	22,240	53,168			6.00
7.00	00700	OPERATION OF PLANT	34,107	12,560	1,066,186		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,834	201	5,980	24,111	8.00
9.00	00900	HOUSEKEEPING	15,479	549	15,495	0	82,652
10.00	01000	DIETARY	8,944	1,592	47,416	930	3,774
11.00	01100	CAFETERIA	16,826	735	21,883	0	1,742
14.00	01400	CENTRAL SERVICES & SUPPLY	8,521	1,067	31,786	0	2,530
15.00	01500	PHARMACY	11,517	370	11,009	0	876
16.00	01600	MEDICAL RECORDS & LIBRARY	38,026	574	17,106	0	1,361
19.00	01900	NONPHYSICIAN ANESTHETISTS	6,440	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	78,917	5,875	175,005	9,140	13,929
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	79,024	5,060	150,734	4,966	11,997
53.00	05300	ANESTHESIOLOGY	2,102	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,852	2,488	74,115	2,456	5,899
54.01	03952	ULTRASOUND	0	0	0	0	0
60.00	06000	LABORATORY	82,938	1,521	45,319	0	3,607
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	36,231	2,768	82,464	1,069	6,563
67.00	06700	OCCUPATIONAL THERAPY	6,629	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	932	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	974	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,841	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,041	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	14,840	0	0	0	0
76.00	03950	SLEEP LAB	5,321	219	6,524	200	519
76.01	03951	DIABETIC EDUCATION	302	0	0	0	0
76.02	03020	SENIOR LIFE SOLUTIONS	13,106	0	0	0	0
76.03	03030	WOUND CARE	4,415	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	17,244	403	0	0	0
88.01	08801	RURAL HEALTH CLINIC II	137,654	7,704	229,489	126	18,266
88.02	08802	RURAL HEALTH CLINIC III	19,626	0	0	0	0
91.00	09100	EMERGENCY	98,294	4,176	124,405	5,082	9,901
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	24,401	2,030	14,932	47	1,188
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	882,618	49,892	1,053,662	24,016	82,152
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	449	209	6,233	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,127	0	0	0	0
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	45,165	149	4,427	0	352
194.01	07951	FOUNDATION	10,278	63	1,864	0	148
194.02	07952	CROSSFIT	6,271	2,855	0	95	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	947,908	53,168	1,066,186	24,111	82,652

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1301

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Cost Center Description			DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	PFS & REGISTRATION						5.01
5.02	00550	ADMINISTRATIVE & GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	230,875					10.00
11.00	01100	CAFETERIA	0	100,216				11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,896	135,511			14.00
15.00	01500	PHARMACY	0	1,246	474	94,383		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,035	497	0	160,295	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	230,875	15,238	3,266	0	23,946	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	7,147	7,423	0	14,698	50.00
53.00	05300	ANESTHESIOLOGY	0	856	703	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,167	3,724	0	3,574	54.00
54.01	03952	ULTRASOUND	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	8,283	42,419	0	20,692	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	7,448	812	0	4,600	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,396	0	0	673	67.00
68.00	06800	SPEECH PATHOLOGY	0	219	0	0	112	68.00
69.00	06900	ELECTROCARDIOLOGY	0	110	0	0	32	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	30,895	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	21,211	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	94,383	0	73.00
76.00	03950	SLEEP LAB	0	1,061	322	0	625	76.00
76.01	03951	DIABETIC EDUCATION	0	75	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	691	47	0	64	76.02
76.03	03030	WOUNDCARE	0	205	0	0	1,523	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	2,390	0	7,613	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	20,206	11,830	0	39,894	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	3,249	0	7,645	88.02
91.00	09100	EMERGENCY	0	12,411	3,473	0	32,793	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	575	0	1,811	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	230,875	97,690	133,310	94,383	160,295	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	81	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	0	952	1,652	0	0	194.00
194.01	07951	FOUNDATION	0	431	12	0	0	194.01
194.02	07952	CROSSFIT	0	1,143	456	0	0	194.02
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)	230,875	100,216	135,511	94,383	160,295	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1301

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From 07/01/2020
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Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING					1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING					1.02
1.03	00103	CROSSFIT BUILDING					1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	PFS & REGISTRATION					5.01
5.02	00550	ADMINISTRATIVE & GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	6,502				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		1,129,652	0	1,129,652	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		1,001,952	0	1,001,952	50.00
53.00	05300	ANESTHESIOLOGY		5,912	0	5,912	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		944,049	0	944,049	54.00
54.01	03952	ULTRASOUND		0	0	0	54.01
60.00	06000	LABORATORY		407,008	0	407,008	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	64.00
66.00	06600	PHYSICAL THERAPY		373,078	0	373,078	66.00
67.00	06700	OCCUPATIONAL THERAPY		9,721	0	9,721	67.00
68.00	06800	SPEECH PATHOLOGY		1,418	0	1,418	68.00
69.00	06900	ELECTROCARDIOLOGY		1,824	0	1,824	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		45,594	0	45,594	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		30,813	0	30,813	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		113,101	0	113,101	73.00
76.00	03950	SLEEP LAB		36,155	0	36,155	76.00
76.01	03951	DIABETIC EDUCATION		412	0	412	76.01
76.02	03020	SENIOR LIFE SOLUTIONS		39,130	0	39,130	76.02
76.03	03030	WOUNDCARE		8,041	0	8,041	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		52,315	0	52,315	88.00
88.01	08801	RURAL HEALTH CLINIC II		1,119,366	0	1,119,366	88.01
88.02	08802	RURAL HEALTH CLINIC III		124,516	0	124,516	88.02
91.00	09100	EMERGENCY		656,402	0	656,402	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES		173,262	0	173,262	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,273,721	0	6,273,721	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		23,667	0	23,667	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		107,783	0	107,783	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO		121,739	0	121,739	194.00
194.01	07951	FOUNDATION		17,834	0	17,834	194.01
194.02	07952	CROSSFIT		79,593	0	79,593	194.02
200.00		Cross Foot Adjustments	6,502	6,502	0	6,502	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,502	6,630,839	0	6,630,839	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1301

Period:
From 07/01/2020
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Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	RURAL HEALTH CLINIC I BUILDING (SQUARE FEET)	RURAL HEALTH CLINIC III BUILDING (SQUARE FEET)	CROSSFIT BUILDING (SQUARE FEET)	AMBULANCE/MAIN TENANCE GARAGE (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	79,402					1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING	0	619				1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING	0	0	5,852			1.02
1.03	00103	CROSSFIT BUILDING	0	0	0	4,380		1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE	0	0	0	0	4,866	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	103	0	0	0	0	4.00
5.01	00540	PFS & REGISTRATION	1,412	0	0	0	0	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	5,939	0	0	0	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	244	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	16,794	0	0	0	2,475	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	308	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	798	0	0	0	45	9.00
10.00	01000	DIETARY	2,442	0	0	0	0	10.00
11.00	01100	CAFETERIA	1,127	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,637	0	0	0	0	14.00
15.00	01500	PHARMACY	567	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	881	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,013	0	0	0	0	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,763	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,817	0	0	0	0	54.00
54.01	03952	ULTRASOUND	0	0	0	0	0	54.01
60.00	06000	LABORATORY	2,334	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	4,247	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	336	0	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	0	0	0	0	76.02
76.03	03030	WOUNDCARE	0	0	0	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	619	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	11,819	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	4,736	0	0	88.02
91.00	09100	EMERGENCY	6,407	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	769	0	0	0	2,346	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	78,757	619	4,736	0	4,866	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	321	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	228	0	1,116	0	0	194.00
194.01	07951	FOUNDATION	96	0	0	0	0	194.01
194.02	07952	CROSSFIT	0	0	0	4,380	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,149,570	18,697	93,205	60,385	14,607	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	52.260271	30.205170	15.927033	13.786530	3.001850	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						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: 14-1301

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

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Date/Time Prepared:
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Cost Center Description		CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PFS & REGISTRATION (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		MVBLE EQUIP (DOLLAR VALUE)					
		2.00	4.00	5.01	5A.02	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING					1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING					1.02
1.03	00103	CROSSFIT BUILDING					1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,741,432				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	16,914,186			4.00
5.01	00540	PFS & REGISTRATION	0	1,021,710	97,350,146		5.01
5.02	00550	ADMINISTRATIVE & GENERAL	584,790	2,915,322	0	-6,906,289	5.02
6.00	00600	MAINTENANCE & REPAIRS	17,660	337,529	0	0	6.00
7.00	00700	OPERATION OF PLANT	126,668	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	8,970	351,355	0	0	9.00
10.00	01000	DIETARY	39,653	90,607	0	0	10.00
11.00	01100	CAFETERIA	0	419,300	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,038	165,680	0	0	14.00
15.00	01500	PHARMACY	38,315	182,236	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,576	721,365	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	195,698	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	88,827	1,389,747	9,220,636	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	168,464	648,569	15,209,967	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,958,212	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	379,816	812,496	15,653,817	0	54.00
54.01	03952	ULTRASOUND	0	0	0	0	54.01
60.00	06000	LABORATORY	64,193	668,029	18,833,595	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	5,252	746,179	4,681,377	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	181,113	1,267,560	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	27,177	191,793	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,161	924,460	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,126,903	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	737,607	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,096,368	0	73.00
76.00	03950	SLEEP LAB	2,002	115,805	657,899	0	76.00
76.01	03951	DIABETIC EDUCATION	0	7,787	43,280	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	38,067	693,226	0	76.02
76.03	03030	WOUNDCARE	0	12,394	424,991	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5,175	386,451	722,946	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	31,414	2,825,448	4,591,974	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	17,440	379,810	790,605	0	88.02
91.00	09100	EMERGENCY	21,786	1,250,196	10,968,535	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	77,163	489,082	2,554,395	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,697,202	16,390,313	97,350,146	-6,906,289	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,168	3,025	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	14,894	355,860	0	0	194.00
194.01	07951	FOUNDATION	0	66,783	0	0	194.01
194.02	07952	CROSSFIT	8,168	98,205	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,781,722	394,687	1,836,342	6,906,289	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.023136	0.023335	0.018863	0.194960	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		5,383	74,117	947,908	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000318	0.000761	0.026759	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: 14-1301

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

Worksheet B-1

Date/Time Prepared:

11/21/2021 10:25 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING					1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING					1.02
1.03	00103	CROSSFIT BUILDING					1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	PFS & REGISTRATION					5.01
5.02	00550	ADMINISTRATIVE & GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS	81,569				6.00
7.00	00700	OPERATION OF PLANT	19,269	54,910			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	308	308	81,090		8.00
9.00	00900	HOUSEKEEPING	843	798	0	53,483	9.00
10.00	01000	DIETARY	2,442	2,442	3,128	2,442	10.00
11.00	01100	CAFETERIA	1,127	1,127	0	1,127	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,637	1,637	0	1,637	14.00
15.00	01500	PHARMACY	567	567	0	567	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	881	881	0	881	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,013	9,013	30,742	9,013	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,763	7,763	16,702	7,763	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,817	3,817	8,259	3,817	54.00
54.01	03952	ULTRASOUND	0	0	0	0	54.01
60.00	06000	LABORATORY	2,334	2,334	0	2,334	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	4,247	4,247	3,594	4,247	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	SLEEP LAB	336	336	671	336	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	0	0	0	76.02
76.03	03030	WOUNDCARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	619	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	11,819	11,819	424	11,819	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
91.00	09100	EMERGENCY	6,407	6,407	17,093	6,407	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,115	769	159	769	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,544	54,265	80,772	53,159	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	321	321	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	228	228	0	228	194.00
194.01	07951	FOUNDATION	96	96	0	96	194.01
194.02	07952	CROSSFIT	4,380	0	318	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	993,147	1,757,717	95,496	727,036	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.175545	32.010872	1.177654	13.593777	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	53,168	1,066,186	24,111	82,652	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.651816	19.416973	0.297336	1.545388	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: 14-1301

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

Worksheet B-1

Date/Time Prepared:

11/21/2021 10:25 am

Cost Center Description			CAFETERIA (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	PFS & REGISTRATION						5.01
5.02	00550	ADMINISTRATIVE & GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	14,640					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	423	2,069,712				14.00
15.00	01500	PHARMACY	182	7,247	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,466	7,593	0	10,001		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,226	49,887	0	1,494	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,044	113,375	0	917	0	50.00
53.00	05300	ANESTHESIOLOGY	125	10,734	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,193	56,883	0	223	0	54.00
54.01	03952	ULTRASOUND	0	0	0	0	0	54.01
60.00	06000	LABORATORY	1,210	647,824	0	1,291	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,088	12,406	0	287	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	204	0	0	42	0	67.00
68.00	06800	SPEECH PATHOLOGY	32	0	0	7	0	68.00
69.00	06900	ELECTROCARDIOLOGY	16	0	0	2	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	471,880	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	323,961	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0	0	73.00
76.00	03950	SLEEP LAB	155	4,924	0	39	0	76.00
76.01	03951	DIABETIC EDUCATION	11	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	101	722	0	4	0	76.02
76.03	03030	WOUND CARE	30	0	0	95	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	36,510	0	475	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,952	180,679	0	2,489	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	49,631	0	477	0	88.02
91.00	09100	EMERGENCY	1,813	53,039	0	2,046	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	8,784	0	113	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,271	2,036,079	100	10,001	100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,241	0	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	139	25,231	0	0	0	194.00
194.01	07951	FOUNDATION	63	190	0	0	0	194.01
194.02	07952	CROSSFIT	167	6,971	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	816,503	498,713	558,982	1,832,587	287,579	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	55.772063	0.240958	5,589.820000	183.240376	2,875.790000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	100,216	135,511	94,383	160,295	6,502	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.845355	0.065473	943.830000	16.027897	65.020000	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: 14-1301

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

Worksheet B-2

Date/Time Prepared:
11/21/2021 10:25 am

		Description	Worksheet		Amount	
			CODE	Line No.		
1.00		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1 74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1 94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1 74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1 94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1 74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1 94.00	0	6.00
7.00		ADULTS & PEDIATRICS		1 30.00	-147,610	7.00
8.00		OTHER OUTPATIENT SERVICES		1 64.00	147,610	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/21/2021 10:25 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	4,887,597		4,887,597	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,250,729		4,250,729	0	0	50.00
53.00	05300	ANESTHESIOLOGY	391,017		391,017	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,604,670		3,604,670	0	0	54.00
54.01	03952	ULTRASOUND	0		0	0	0	54.01
60.00	06000	LABORATORY	4,298,713		4,298,713	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	147,610		147,610	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,983,807	0	1,983,807	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	315,094	0	315,094	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	44,697	0	44,697	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	44,765		44,765	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	731,775		731,775	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	481,807		481,807	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,221,683		1,221,683	0	0	73.00
76.00	03950	SLEEP LAB	274,795		274,795	0	0	76.00
76.01	03951	DIABETIC EDUCATION	14,121		14,121	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	591,806		591,806	0	0	76.02
76.03	03030	WOUNDCARE	216,248		216,248	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	873,414		873,414	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,495,133		7,495,133	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	975,811		975,811	0	0	88.02
91.00	09100	EMERGENCY	5,268,588		5,268,588	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	670,024		670,024		0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,185,668		1,185,668	0	0	95.00
200.00		Subtotal (see instructions)	39,969,572	0	39,969,572	0	0	200.00
201.00		Less Observation Beds	670,024		670,024		0	201.00
202.00		Total (see instructions)	39,299,548	0	39,299,548	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/21/2021 10:25 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	8,058,261		8,058,261		30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	150,465	15,059,502	15,209,967	0.279470	50.00
53.00	05300	ANESTHESIOLOGY	32,309	2,925,903	2,958,212	0.132180	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	295,599	15,358,218	15,653,817	0.230274	54.00
54.01	03952	ULTRASOUND	0	0	0	0.000000	54.01
60.00	06000	LABORATORY	643,841	18,189,754	18,833,595	0.228247	60.00
64.00	06400	INTRAVENOUS THERAPY	13,352	498,002	511,354	0.288665	64.00
66.00	06600	PHYSICAL THERAPY	437,044	4,244,333	4,681,377	0.423766	66.00
67.00	06700	OCCUPATIONAL THERAPY	424,139	843,421	1,267,560	0.248583	67.00
68.00	06800	SPEECH PATHOLOGY	55,389	136,404	191,793	0.233048	68.00
69.00	06900	ELECTROCARDIOLOGY	10,762	913,698	924,460	0.048423	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	109,911	1,016,992	1,126,903	0.649368	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,943	696,664	737,607	0.653203	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,029,136	4,067,232	5,096,368	0.239716	73.00
76.00	03950	SLEEP LAB	0	657,899	657,899	0.417686	76.00
76.01	03951	DIABETIC EDUCATION	0	43,280	43,280	0.326271	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	693,226	693,226	0.853699	76.02
76.03	03030	WOUNDCARE	988	424,003	424,991	0.508830	76.03
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	722,946	722,946		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,591,974	4,591,974		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	790,605	790,605		88.02
91.00	09100	EMERGENCY	0	10,968,535	10,968,535	0.480337	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,852	641,169	651,021	1.029190	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,554,395	2,554,395	0.464168	95.00
200.00		Subtotal (see instructions)	11,311,991	86,038,155	97,350,146		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	11,311,991	86,038,155	97,350,146		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/21/2021 10:25 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					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	03952 ULTRASOUND	0.000000			54.01
60.00	06000 LABORATORY	0.000000			60.00
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
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950 SLEEP LAB	0.000000			76.00
76.01	03951 DIABETIC EDUCATION	0.000000			76.01
76.02	03020 SENIOR LIFE SOLUTIONS	0.000000			76.02
76.03	03030 WOUNDCARE	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
88.01	08801 RURAL HEALTH CLINIC II				88.01
88.02	08802 RURAL HEALTH CLINIC III				88.02
91.00	09100 EMERGENCY	0.000000			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
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: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/21/2021 10:25 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Program Charges	Capital Costs (column 3 x column 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,001,952	15,209,967	0.065875	48,258	3,179	50.00
53.00	05300 ANESTHESIOLOGY	5,912	2,958,212	0.001999	1,067	2	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	944,049	15,653,817	0.060308	46,452	2,801	54.00
54.01	03952 ULTRASOUND	0	0	0.000000	0	0	54.01
60.00	06000 LABORATORY	407,008	18,833,595	0.021611	87,749	1,896	60.00
64.00	06400 INTRAVENOUS THERAPY	0	511,354	0.000000	2,952	0	64.00
66.00	06600 PHYSICAL THERAPY	373,078	4,681,377	0.079694	14,859	1,184	66.00
67.00	06700 OCCUPATIONAL THERAPY	9,721	1,267,560	0.007669	8,512	65	67.00
68.00	06800 SPEECH PATHOLOGY	1,418	191,793	0.007393	1,228	9	68.00
69.00	06900 ELECTROCARDIOLOGY	1,824	924,460	0.001973	1,628	3	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	45,594	1,126,903	0.040460	23,765	962	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	30,813	737,607	0.041774	18,296	764	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	113,101	5,096,368	0.022192	110,327	2,448	73.00
76.00	03950 SLEEP LAB	36,155	657,899	0.054955	0	0	76.00
76.01	03951 DIABETIC EDUCATION	412	43,280	0.009519	0	0	76.01
76.02	03020 SENIOR LIFE SOLUTIONS	39,130	693,226	0.056446	0	0	76.02
76.03	03030 WOUNDCARE	8,041	424,991	0.018920	988	19	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	52,315	722,946	0.072364	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	1,119,366	4,591,974	0.243766	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	124,516	790,605	0.157495	0	0	88.02
91.00	09100 EMERGENCY	656,402	10,968,535	0.059844	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	154,860	651,021	0.237873	2,050	488	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	5,125,667	86,737,490		368,131	13,820	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/21/2021 10:25 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	287,579	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	03952	ULTRASOUND	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	SLEEP LAB	0	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	0	0	0	76.02
76.03	03030	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	287,579	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1301		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/21/2021 10:25 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								
50.00	05000	OPERATING ROOM	0	0	0	15,209,967	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	287,579	0	2,958,212	0.097214	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,653,817	0.000000	54.00
54.01	03952	ULTRASOUND	0	0	0	0	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	18,833,595	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	511,354	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,681,377	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,267,560	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	191,793	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	924,460	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,126,903	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	737,607	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,096,368	0.000000	73.00
76.00	03950	SLEEP LAB	0	0	0	657,899	0.000000	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	43,280	0.000000	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	0	0	693,226	0.000000	76.02
76.03	03030	WOUNDCARE	0	0	0	424,991	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	722,946	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	4,591,974	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	790,605	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	10,968,535	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	651,021	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	287,579	0	86,737,490		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1301

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

Worksheet D
Part IV
Date/Time Prepared:
11/21/2021 10:25 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								
50.00	05000	OPERATING ROOM	0.000000	48,258	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,067	104	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	46,452	0	0	0	54.00
54.01	03952	ULTRASOUND	0.000000	0	0	0	0	54.01
60.00	06000	LABORATORY	0.000000	87,749	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	2,952	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	14,859	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	8,512	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,228	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,628	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	23,765	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	18,296	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	110,327	0	0	0	73.00
76.00	03950	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.000000	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0.000000	0	0	0	0	76.02
76.03	03030	WOUNDCARE	0.000000	988	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,050	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		368,131	104	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/21/2021 10:25 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							
50.00	05000	OPERATING ROOM	0.279470	0	3,641,780	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.132180	0	652,851	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230274	0	3,603,404	0	0	54.00
54.01	03952	ULTRASOUND	0.000000	0	0	0	0	54.01
60.00	06000	LABORATORY	0.228247	0	4,266,150	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.288665	0	210,901	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.423766	0	937,415	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.248583	0	203,604	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.233048	0	7,749	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048423	0	235,105	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.649368	0	300,088	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.653203	0	187,796	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.239716	0	1,829,685	20,362	0	73.00
76.00	03950	SLEEP LAB	0.417686	0	119,083	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.326271	0	8,004	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0.853699	0	578,995	0	0	76.02
76.03	03030	WOUNDCARE	0.508830	0	158,064	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
91.00	09100	EMERGENCY	0.480337	0	2,342,186	21,928	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.029190	0	249,526	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.464168		0			95.00
200.00		Subtotal (see instructions)		0	19,532,386	42,290	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
202.00		Only Charges						
202.00		Net Charges (line 200 - line 201)		0	19,532,386	42,290	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/21/2021 10:25 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					
50.00	05000	OPERATING ROOM	1,017,768	0		50.00
53.00	05300	ANESTHESIOLOGY	86,294	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	829,770	0		54.00
54.01	03952	ULTRASOUND	0	0		54.01
60.00	06000	LABORATORY	973,736	0		60.00
64.00	06400	INTRAVENOUS THERAPY	60,880	0		64.00
66.00	06600	PHYSICAL THERAPY	397,245	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	50,612	0		67.00
68.00	06800	SPEECH PATHOLOGY	1,806	0		68.00
69.00	06900	ELECTROCARDIOLOGY	11,384	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	194,868	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	122,669	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	438,605	4,881		73.00
76.00	03950	SLEEP LAB	49,739	0		76.00
76.01	03951	DIABETIC EDUCATION	2,611	0		76.01
76.02	03020	SENIOR LIFE SOLUTIONS	494,287	0		76.02
76.03	03030	WOUNDCARE	80,428	0		76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
91.00	09100	EMERGENCY	1,125,039	10,533		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	256,810	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	6,194,551	15,414		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,194,551	15,414		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1301

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

Worksheet D-1

Date/Time Prepared:
11/21/2021 10:25 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)	2,171	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	489	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)	228	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	745	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)	651	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	192	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)	94	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	108	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)	309	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)	309	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)	4,887,597	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)	32,584	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)	15,953	25.00
26.00	Total swing-bed cost (see instructions)	3,632,264	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,255,333	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)	1,255,333	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)	2,567.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	277,251	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)	277,251	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1301

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

Worksheet D-1

Date/Time Prepared:
11/21/2021 10:25 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Program Cost (col. 3 x col. 4)	Cost
		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)					110,426	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					387,677	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)					793,246	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					793,246	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,586,492	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)					261	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,567.14	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					670,024	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1301

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

Worksheet D-1

Date/Time Prepared:
11/21/2021 10:25 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,129,652	4,887,597	0.231126	670,024	154,860	90.00
91.00	Nursing School cost	0	4,887,597	0.000000	670,024	0	91.00
92.00	Allied health cost	0	4,887,597	0.000000	670,024	0	92.00
93.00	All other Medical Education	0	4,887,597	0.000000	670,024	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/21/2021 10:25 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		508,882		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.279470	48,258	13,487	50.00
53.00	05300 ANESTHESIOLOGY	0.132180	1,067	141	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230274	46,452	10,697	54.00
54.01	03952 ULTRASOUND	0.000000	0	0	54.01
60.00	06000 LABORATORY	0.228247	87,749	20,028	60.00
64.00	06400 INTRAVENOUS THERAPY	0.288665	2,952	852	64.00
66.00	06600 PHYSICAL THERAPY	0.423766	14,859	6,297	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.248583	8,512	2,116	67.00
68.00	06800 SPEECH PATHOLOGY	0.233048	1,228	286	68.00
69.00	06900 ELECTROCARDIOLOGY	0.048423	1,628	79	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.649368	23,765	15,432	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.653203	18,296	11,951	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.239716	110,327	26,447	73.00
76.00	03950 SLEEP LAB	0.417686	0	0	76.00
76.01	03951 DIABETIC EDUCATION	0.326271	0	0	76.01
76.02	03020 SENIOR LIFE SOLUTIONS	0.853699	0	0	76.02
76.03	03030 WOUNDCARE	0.508830	988	503	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100 EMERGENCY	0.480337	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.029190	2,050	2,110	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)		368,131	110,426	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)		368,131		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1301 Component CCN: 14-Z301	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/21/2021 10:25 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					
50.00	05000 OPERATING ROOM	0.279470	11,651	3,256	50.00
53.00	05300 ANESTHESIOLOGY	0.132180	1,067	141	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230274	152,157	35,038	54.00
54.01	03952 ULTRASOUND	0.000000	0	0	54.01
60.00	06000 LABORATORY	0.228247	199,386	45,509	60.00
64.00	06400 INTRAVENOUS THERAPY	0.288665	8,856	2,556	64.00
66.00	06600 PHYSICAL THERAPY	0.423766	161,269	68,340	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.248583	172,114	42,785	67.00
68.00	06800 SPEECH PATHOLOGY	0.233048	28,118	6,553	68.00
69.00	06900 ELECTROCARDIOLOGY	0.048423	3,436	166	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.649368	31,845	20,679	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.653203	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.239716	259,513	62,209	73.00
76.00	03950 SLEEP LAB	0.417686	0	0	76.00
76.01	03951 DIABETIC EDUCATION	0.326271	0	0	76.01
76.02	03020 SENIOR LIFE SOLUTIONS	0.853699	0	0	76.02
76.03	03030 WOUNDCARE	0.508830	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100 EMERGENCY	0.480337	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.029190	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)		1,029,412	287,232	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,029,412		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/21/2021 10:25 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		6,209,965	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)		6,209,965	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		6,272,065	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)		29,468	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,954,278	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		3,288,319	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		3,288,319	30.00
31.00	Primary payer payments		1,738	31.00
32.00	Subtotal (line 30 minus line 31)		3,286,581	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)		308,433	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		200,481	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		131,330	36.00
37.00	Subtotal (see instructions)		3,487,062	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,487,062	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		3,974,288	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)		-487,226	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: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/21/2021 10:25 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		388,380		3,866,688	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	01/28/2021	107,600	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		107,600	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)		388,380		3,974,288	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		30,788		487,226	6.02
7.00	Total Medicare program liability (see instructions)		357,592		3,487,062	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: 14-1301

Period:

Worksheet E-1

Component CCN: 14-Z301

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
11/21/2021 10:25 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		2,205,542		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,205,542		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		327,789		0	6.02
7.00	Total Medicare program liability (see instructions)		1,877,753		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: 14-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part II Date/Time Prepared: 11/21/2021 10:25 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, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet E-2	
		Component CCN: 14-Z301		Date/Time Prepared: 11/21/2021 10:25 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)		1,602,357	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)		290,104	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		618	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)		1,892,461	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,892,461	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,892,461	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		14,926	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,877,535	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)		335	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		218	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,877,753	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		2,205,542	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)		-327,789	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: 14-1301	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part V Date/Time Prepared: 11/21/2021 10:25 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		387,677	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)		387,677	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		391,554	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)		391,554	19.00
20.00	Deductibles (exclude professional component)		36,340	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		355,214	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		355,214	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		3,659	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		2,378	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		357,592	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		357,592	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		0	30.03
31.00	Interim payments		388,380	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		-30,788	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	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: 14-1301

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

Worksheet G

Date/Time Prepared:
11/21/2021 10:25 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	12,882,511	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,371,506	0	0	0	4.00
5.00	Other receivable	291,725	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	924,178	0	0	0	7.00
8.00	Prepaid expenses	1,392,176	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	20,862,096	0	0	0	11.00
FIXED ASSETS						
12.00	Land	8,007,082	0	0	0	12.00
13.00	Land improvements	24,732,360	0	0	0	13.00
14.00	Accumulated depreciation	-3,326,263	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	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	32,035,156	0	0	0	19.00
20.00	Accumulated depreciation	-29,138,342	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	1,532,446	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	33,842,439	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	4,336,244	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	57,579,062	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	61,915,306	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	116,619,841	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,451,923	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,287,657	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,118,212	0	0	0	40.00
41.00	Deferred income	917,810	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	1,688,742	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,464,344	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	27,556,322	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	256,539	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	27,812,861	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	36,277,205	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	80,342,636	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)	80,342,636	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	116,619,841	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1301

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

Worksheet G-1

Date/Time Prepared:
11/21/2021 10:25 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		67,789,553		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		12,837,864				2.00
3.00	Total (sum of line 1 and line 2)		80,627,417		0		3.00
4.00	CHANGE IN INTEREST PERPETUAL TRUST	91,894		0		0	4.00
5.00	AUXILIARY GAIN	84,499		0		0	5.00
6.00	ROUNDING	2		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)		176,395		0		10.00
11.00	Subtotal (line 3 plus line 10)		80,803,812		0		11.00
12.00	CAPITAL CONTRIBUTIONS	460,548		0		0	12.00
13.00	ASSETS RELEASED FROM RESTRICTION	628		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)		461,176		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		80,342,636		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	CHANGE IN INTEREST PERPETUAL TRUST		0				4.00
5.00	AUXILIARY GAIN		0				5.00
6.00	ROUNDING		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	CAPITAL CONTRIBUTIONS		0				12.00
13.00	ASSETS RELEASED FROM RESTRICTION		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: 14-1301

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/21/2021 10:25 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,087,549		2,087,549	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	5,522,808		5,522,808	5.00
6.00	Swing bed - NF	447,903		447,903	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)	8,058,260		8,058,260	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)	8,058,260		8,058,260	17.00
18.00	Ancillary services	3,243,878	65,768,531	69,012,409	18.00
19.00	Outpatient services	9,852	11,609,704	11,619,556	19.00
20.00	RURAL HEALTH CLINIC	0	722,946	722,946	20.00
20.01	RURAL HEALTH CLINIC II	0	4,591,974	4,591,974	20.01
20.02	RURAL HEALTH CLINIC III	0	790,605	790,605	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,554,395	2,554,395	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	241,797	10,900,441	11,142,238	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,553,787	96,938,596	108,492,383	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		47,880,527		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)		47,880,527		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1301

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

Worksheet G-3

Date/Time Prepared:
11/21/2021 10:25 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	108,492,383	1.00
2.00	Less contractual allowances and discounts on patients' accounts	61,544,318	2.00
3.00	Net patient revenues (line 1 minus line 2)	46,948,065	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	47,880,527	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-932,462	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	2,144,248	6.00
7.00	Income from investments	4,550,468	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	172,218	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	3	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	34,871	22.00
23.00	Governmental appropriations	0	23.00
24.00	340B PHARMACY REVENUE	556,880	24.00
24.01	GRANT INCOME	3,568,782	24.01
24.02	FOUNDATION INCOME	794,290	24.02
24.03	RETAIL PHARMACY INCOME	1,337,802	24.03
24.04	TIF INCOME	66,739	24.04
24.05	AMBULANCE INCOME	58,874	24.05
24.06	MISCELLANEOUS INCOME	194,733	24.06
24.50	COVID-19 PHE Funding	300,000	24.50
25.00	Total other income (sum of lines 6-24)	13,779,908	25.00
26.00	Total (line 5 plus line 25)	12,847,446	26.00
27.00	LOSS ON DISPOSAL OF ASSETS	9,582	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	9,582	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	12,837,864	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301

Period:

Worksheet M-1

Component CCN: 14-3438

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/21/2021 10:25 am

		RHC I		Cost		
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	115,721	0	115,721	0	115,721 1.00
2.00	Physician Assistant	129,271	0	129,271	-33,997	95,274 2.00
3.00	Nurse Practitioner	3,754	0	3,754	0	3,754 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	108,186	0	108,186	0	108,186 5.00
6.00	Clinical Psychologist	0	0	0	0	0 6.00
7.00	Clinical Social Worker	31,611	0	31,611	0	31,611 7.00
8.00	Laboratory Technician	0	0	0	0	0 8.00
9.00	Other Facility Health Care Staff Costs	0	776	776	0	776 9.00
10.00	Subtotal (sum of lines 1 through 9)	388,543	776	389,319	-33,997	355,322 10.00
11.00	Physician Services Under Agreement	0	0	0	0	0 11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0 12.00
13.00	Other Costs Under Agreement	0	0	0	0	0 13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0 14.00
15.00	Medical Supplies	0	28,835	28,835	0	28,835 15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0 16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00	Professional Liability Insurance	0	0	0	0	0 18.00
19.00	Other Health Care Costs	0	0	0	0	0 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	28,835	28,835	0	28,835 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	388,543	29,611	418,154	-33,997	384,157 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0 23.00
24.00	Dental	0	0	0	0	0 24.00
25.00	Optometry	0	0	0	0	0 25.00
25.01	Telehealth	0	0	0	33,997	33,997 25.01
25.02	Chronic Care Management	0	0	0	0	0 25.02
26.00	All other nonreimbursable costs	0	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	33,997	33,997 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	11,259	11,259	-3,379	7,880 29.00
30.00	Administrative Costs	58,671	172,165	230,836	-80,582	150,254 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	58,671	183,424	242,095	-83,961	158,134 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	447,214	213,035	660,249	-83,961	576,288 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301

Period:

Worksheet M-1

Component CCN: 14-3438

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/21/2021 10:25 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	115,721	1.00
2.00	Physician Assistant	0	95,274	2.00
3.00	Nurse Practitioner	0	3,754	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	108,186	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	31,611	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	776	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	355,322	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	28,835	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	28,835	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	384,157	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	33,997	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			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	33,997	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	7,880	29.00
30.00	Administrative Costs	21,472	171,726	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	21,472	179,606	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	21,472	597,760	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301

Period:

Worksheet M-1

Component CCN: 14-3495

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/21/2021 10:25 am

				RHC II		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,063,199	0	1,063,199	-64,008	999,191	1.00
2.00	Physician Assistant	118,447	0	118,447	-7,067	111,380	2.00
3.00	Nurse Practitioner	530,139	0	530,139	-115,068	415,071	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	790,090	0	790,090	-162	789,928	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	160,499	41,572	202,071	0	202,071	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	3,233	3,233	0	3,233	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,662,374	44,805	2,707,179	-186,305	2,520,874	10.00
11.00	Physician Services Under Agreement	0	638,997	638,997	-2,611	636,386	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	638,997	638,997	-2,611	636,386	14.00
15.00	Medical Supplies	0	131,860	131,860	0	131,860	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	131,860	131,860	0	131,860	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,662,374	815,662	3,478,036	-188,916	3,289,120	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	188,754	188,754	25.01
25.02	Chronic Care Management	0	0	0	162	162	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	188,916	188,916	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	3,274	3,274	0	3,274	29.00
30.00	Administrative Costs	477,460	1,020,183	1,497,643	-395,260	1,102,383	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	477,460	1,023,457	1,500,917	-395,260	1,105,657	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,139,834	1,839,119	4,978,953	-395,260	4,583,693	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301

Period:

Worksheet M-1

Component CCN: 14-3495

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/21/2021 10:25 am

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	999,191	1.00
2.00	Physician Assistant	0	111,380	2.00
3.00	Nurse Practitioner	0	415,071	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	789,928	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	202,071	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	3,233	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,520,874	10.00
11.00	Physician Services Under Agreement	-299,894	336,492	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)	-299,894	336,492	14.00
15.00	Medical Supplies	0	131,860	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	131,860	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-299,894	2,989,226	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	188,754	25.01
25.02	Chronic Care Management	0	162	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	188,916	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	3,274	29.00
30.00	Administrative Costs	58,356	1,160,739	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	58,356	1,164,013	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-241,538	4,342,155	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301

Period:

Worksheet M-1

Component CCN: 14-8566

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/21/2021 10:25 am

		RHC III		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	55,089	0	55,089	0	55,089
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	171,018	0	171,018	-26,125	144,893
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	122,168	0	122,168	0	122,168
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	30,829	0	30,829	0	30,829
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	919	919	0	919
10.00	Subtotal (sum of lines 1 through 9)	379,104	919	380,023	-26,125	353,898
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	40,308	40,308	0	40,308
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	40,308	40,308	0	40,308
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	379,104	41,227	420,331	-26,125	394,206
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	26,125	26,125
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	26,125	26,125
FACILITY OVERHEAD						
29.00	Facility Costs	0	23,372	23,372	0	23,372
30.00	Administrative Costs	81,815	169,701	251,516	-106,461	145,055
31.00	Total Facility Overhead (sum of lines 29 and 30)	81,815	193,073	274,888	-106,461	168,427
32.00	Total facility costs (sum of lines 22, 28 and 31)	460,919	234,300	695,219	-106,461	588,758

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301

Period:

Worksheet M-1

Component CCN: 14-8566

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/21/2021 10:25 am

		RHC III		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	55,089	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	144,893	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	122,168	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	30,829	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	919	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	353,898	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	40,308	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	40,308	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	394,206	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	26,125	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			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	26,125	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	23,372	29.00
30.00	Administrative Costs	27,645	172,700	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	27,645	196,072	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	27,645	616,403	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1301

Period:

Worksheet M-2

Component CCN: 14-3438

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/21/2021 10:25 am

		RHC I		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.37	693	1	0
2.00	Physician Assistant	0.62	1,404	1	1
3.00	Nurse Practitioner	0.03	96	1	0
4.00	Subtotal (sum of lines 1 through 3)	1.02	2,193	1	2,193
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.25	315		315
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.27	2,508		2,508
9.00	Physician Services Under Agreements		0		0
					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)				384,157
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				33,997
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				418,154
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.918697
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				179,606
15.00	Parent provider overhead allocated to facility (see instructions)				275,654
16.00	Total overhead (sum of lines 14 and 15)				455,260
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				455,260
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				418,246
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				802,403

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1301

Period:

Worksheet M-2

Component CCN: 14-3495

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/21/2021 10:25 am

		RHC II		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	2.49	7,280	1	2
2.00	Physician Assistant	0.75	1,844	1	1
3.00	Nurse Practitioner	3.66	4,628	1	4
4.00	Subtotal (sum of lines 1 through 3)	6.90	13,752		7
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	1.39	1,325		1,325
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	8.29	15,077		15,077
9.00	Physician Services Under Agreements		699		699
					1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES					
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				2,989,226
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				188,916
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				3,178,142
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.940558
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				1,164,013
15.00	Parent provider overhead allocated to facility (see instructions)				3,152,978
16.00	Total overhead (sum of lines 14 and 15)				4,316,991
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				4,316,991
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				4,060,380
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				7,049,606

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1301

Period:

Worksheet M-2

Component CCN: 14-8566

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/21/2021 10:25 am

		RHC III		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.25	520	1	0
2.00	Physician Assistant	0.00	0	1	0
3.00	Nurse Practitioner	1.29	2,163	1	1
4.00	Subtotal (sum of lines 1 through 3)	1.54	2,683	1	2,683
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.35	330		330
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.89	3,013		3,013
9.00	Physician Services Under Agreements		0		0
					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)				394,206
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				26,125
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				420,331
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.937847
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				196,072
15.00	Parent provider overhead allocated to facility (see instructions)				359,408
16.00	Total overhead (sum of lines 14 and 15)				555,480
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				555,480
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				520,955
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				915,161

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1301 Component CCN: 14-3438	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/21/2021 10:25 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)			802,403	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			38,592	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			763,811	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,508	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)			2,508	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			304.55	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	209.38	8.00
9.00	Rate for Program covered visits (see instructions)	304.55	304.55	209.38	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	295	98	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	89,842	20,519	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	12	7	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	3,655	1,466	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	3,655	1,466	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	115,482		16.00
16.01	Total program charges (see instructions)(from contractor's records)		100,651		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		10,823		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		12,418		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.)		74,287		16.04
16.05	Total program cost (see instructions)	0	86,705		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		10,205		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		15,925		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		86,705		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,706		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		93,411		22.00
23.00	Allowable bad debts (see instructions)		7,065		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		4,592		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,504		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)		98,003		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		69,186		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)		28,817		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1301 Component CCN: 14-3495	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/21/2021 10:25 am	
		Title XVIII	RHC II	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			7,049,606	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			110,539	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			6,939,067	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			15,077	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			699	5.00
6.00	Total adjusted visits (line 4 plus line 5)			15,776	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			439.85	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	376.21	8.00
9.00	Rate for Program covered visits (see instructions)	439.85	439.85	376.21	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,868	649	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	821,640	244,160	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	32	2	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	14,075	752	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	14,075	752	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,080,627		16.00
16.01	Total program charges (see instructions)(from contractor's records)		570,539		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		52,217		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		98,901		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.)		740,658		16.04
16.05	Total program cost (see instructions)	0	839,559		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		55,904		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		101,062		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		839,559		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		23,399		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		862,958		22.00
23.00	Allowable bad debts (see instructions)		21,201		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		13,781		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		12,638		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)		876,739		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		700,960		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)		175,779		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1301 Component CCN: 14-8566	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/21/2021 10:25 am	
		Title XVIII	RHC III	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			915,161	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			35,918	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			879,243	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,013	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			3,013	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			291.82	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	331.81	8.00
9.00	Rate for Program covered visits (see instructions)	291.82	291.82	291.82	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	355	141	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	103,596	41,147	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	144,743		16.00
16.01	Total program charges (see instructions)(from contractor's records)		110,340		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,266		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		9,531		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.)		98,234		16.04
16.05	Total program cost (see instructions)	0	107,765		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		12,419		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		18,131		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		107,765		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		10,676		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		118,441		22.00
23.00	Allowable bad debts (see instructions)		2,998		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		1,949		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		2,356		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)		120,390		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		111,150		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)		9,240		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: 14-1301

Period:

Worksheet M-4

Component CCN: 14-3438

From 07/01/2020

Date/Time Prepared:

To 06/30/2021

11/21/2021 10:25 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)	355,322	355,322	355,322	355,322	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001442	0.003939	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	512	1,400	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	12,322	4,242	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	12,834	5,642	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	384,157	384,157	384,157	384,157	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	418,246	418,246	418,246	418,246	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.033408	0.014687	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	13,973	6,143	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	26,807	11,785	0	0	10.00
11.00	Total number of injections/infusions (from your records)	67	183	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	400.10	64.40	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	10	42	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	4,001	2,705	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		38,592			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)		6,706			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1301

Period:

Worksheet M-4

Component CCN: 14-3495

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/21/2021 10:25 am

		Title XVIII		RHC II	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,520,874	2,520,874	2,520,874	2,520,874	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000558	0.002126	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,407	5,359	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	27,068	13,038	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	28,475	18,397	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,989,226	2,989,226	2,989,226	2,989,226	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	4,060,380	4,060,380	4,060,380	4,060,380	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.009526	0.006154	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	38,679	24,988	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	67,154	43,385	0	0	10.00
11.00	Total number of injections/infusions (from your records)	155	590	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	433.25	73.53	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	35	112	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	15,164	8,235	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		110,539			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)		23,399			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1301

Period:

Worksheet M-4

Component CCN: 14-8566

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/21/2021 10:25 am

		Title XVIII		RHC III	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	353,898	353,898	353,898	353,898	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000942	0.003504	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	333	1,240	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	9,011	4,888	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	9,344	6,128	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	394,206	394,206	394,206	394,206	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	520,955	520,955	520,955	520,955	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.023703	0.015545	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	12,348	8,098	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	21,692	14,226	0	0	10.00
11.00	Total number of injections/infusions (from your records)	54	201	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	401.70	70.78	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	19	43	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	7,632	3,044	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		35,918			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		10,676			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1301 Component CCN: 14-3438	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/21/2021 10:25 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		69,186	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		69,186	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		28,817	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		98,003	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1301 Component CCN: 14-3495	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/21/2021 10:25 am
		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		700,960	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		700,960	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		175,779	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		876,739	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1301 Component CCN: 14-8566	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/21/2021 10:25 am
		RHC III	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		111,150	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		111,150	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		9,240	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		120,390	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00