

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: 14-1304	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/18/2021 8:01 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 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 GENESIS MEDICAL CENTER - ALEDO (14-1304) 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) JOSEPH MALAS
 Officer or Administrator of Provider(s)

VICE PRESIDENT, FINANCE
 Title

11/18/2021 08:01:35 AM
 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	142,687	278,896	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	209,229	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		44,062		0	10.00
200.00	Total	0	351,916	322,958	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: 14-1304		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/18/2021 8:01 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: S			PO Box:				1.00			
2.00	City: ALEDO			State: IL		Zip Code: 61231-		County: MERCER			
		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		GENESIS MEDICAL CENTER - ALEDO		141304	19340	1	05/01/2000	N	O	N
4.00	Subprovider - IPF										3.00
5.00	Subprovider - IRF										4.00
6.00	Subprovider - (Other)										5.00
7.00	Swing Beds - SNF		GENESIS MEDICAL CENTER - ALEDO SWB		14Z304	19340		05/01/2000	N	O	N
8.00	Swing Beds - NF										7.00
9.00	Hospital-Based SNF										8.00
10.00	Hospital-Based NF										9.00
11.00	Hospital-Based OLTC										10.00
12.00	Hospital-Based HHA										11.00
13.00	Separately Certified ASC										12.00
14.00	Hospital-Based Hospice										13.00
15.00	Hospital-Based Health Clinic - RHC		GENESIS MEDICAL CENTER - ALEDO RHC		143453	19340		02/29/2000	N	O	N
16.00	Hospital-Based Health Clinic - FQHC										14.00
17.00	Hospital-Based (CMHC) I										15.00
18.00	Renal Dialysis										16.00
19.00	Other										17.00
							From:		To:		
							1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020		06/30/2021		
21.00	Type of Control (see instructions)						2				
							1.00		2.00		
							2.00		3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N				
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N				
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N				
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N			
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.										
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.						0				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/18/2021 8:01 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 S 1.00	Date of Geogr 2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning: 1.00	Ending: 2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N 1.00	Y/N 2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1304		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/18/2021 8:01 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
			0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1304	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/18/2021 8:01 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
			V 1.00	XIX 2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	Y	N	N
			1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1304	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/18/2021 8:01 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	20,940	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)	Y	H55790	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1304		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/18/2021 8:01 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: GENESIS HEALTH SYSTEM		Contractor's Name: WISCONSIN PHYSICIAN SERVICE HEALTH		Contractor's Number: 05001				141.00
142.00	Street: 1227 E RUSHOLME STREET		PO Box:						142.00
143.00	City: DAVENPORT		State: IA		Zip Code: 52803		143.00		
								1.00	
144.00 Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.								145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N		146.00
								1.00	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		155.00
156.00	Subprovider - IPF			N	N	N	N		156.00
157.00	Subprovider - IRF			N	N	N	N		157.00
158.00	SUBPROVIDER								158.00
159.00	SNF			N	N	N	N		159.00
160.00	HOME HEALTH AGENCY			N	N	N	N		160.00
161.00	CMHC				N	N	N		161.00
								1.00	
Multicampus									
165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus
				0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00
						1.00	2.00		
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								N	0
									171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1304		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part II Date/Time Prepared: 11/18/2021 8:01 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			Y			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	10/20/2021	Y	10/20/2021
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: 14-1304	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/18/2021 8:01 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				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.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		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.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BRENT	DAILY	41.00
42.00	Enter the employer/company name of the cost report preparer.	GENESIS HEALTH SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-421-1985	DAILY@GENESISHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/18/2021 8:01 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.	REIMBURSEMENT MANAGER	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: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/18/2021 8:01 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	22	8,030	6,000.00	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)		22	8,030	6,000.00	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)		22	8,030	6,000.00	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
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		22				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: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/18/2021 8:01 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)	151	0	250			1.00
2.00	HMO and other (see instructions)	69	16				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	384	0	587			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	48			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	535	0	885			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)	535	0	885	0.00	76.03	14.00
15.00	CAH visits	5,585	3,685	20,620			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	3,250	5,061	19,281	0.00	18.41	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	94.44	27.00
28.00	Observation Bed Days		3	239			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/18/2021 8:01 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	37	0	70	1.00
2.00 HMO and other (see instructions)			14	3		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	37	0	70	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
26.25 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: 14-1304 Component CCN: 14-3453		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 11/18/2021 8:01 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			1007 NW 3RD STREET			1.00		
			City		State		ZIP Code		
			1.00		2.00		3.00		
2.00	City, State, ZIP Code, County			ALEDO		IL 61231		2.00	
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)							4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00	
7.00	Appalachian Regional Commission							7.00	
8.00	Look-Alikes							8.00	
9.00	OTHER (SPECIFY)							9.00	
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC			07:00		18:00		08:00	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			MERCER				2.00	
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC			17:00		08:00		17:00	
				08:00		17:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1304

Period:

Worksheet S-8

Component CCN: 14-3453

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

Date/Time Prepared:

11/18/2021 8:01 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	07:00	18:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1304

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

Worksheet S-10

Date/Time Prepared:
11/18/2021 8:01 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)		0.566833	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,461,680	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		4,254,819	6.00
7.00	Medicaid cost (line 1 times line 6)		2,411,772	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)		950,092	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		17,338	9.00
10.00	Stand-alone CHIP charges		32,054	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		18,169	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		831	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		950,923	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)	332,610	0	332,610
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	188,534	0	188,534
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	188,534	0	188,534
			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)		584,597	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		96,091	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		147,832	27.01
28.00	Non-Medicare bad debt expense (see instructions)		436,765	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		299,314	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		487,848	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,438,771	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1304

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

Worksheet A

Date/Time Prepared:
11/18/2021 8:01 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		793,827	793,827	36,563	830,390	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		375,758	375,758	232	375,990	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	55,279	713,796	769,075	0	769,075	4.00
5.01	00570	ADMITTING	131,008	13,224	144,232	0	144,232	5.01
5.02	00590	HOSPITAL ONLY A & G	0	205,157	205,157	0	205,157	5.02
5.03	00591	SHARED ADMN & GENERAL	564,011	3,252,923	3,816,934	161,445	3,978,379	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	535,330	535,330	0	535,330	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,212	1,971	28,183	0	28,183	8.00
9.00	00900	HOUSEKEEPING	0	199,922	199,922	0	199,922	9.00
10.00	01000	DIETARY	0	48	48	0	48	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,933	18,180	37,113	0	37,113	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	36,248	5,378	41,626	0	41,626	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	263,253	263,253	-119,040	144,213	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	874,561	166,349	1,040,910	-12,162	1,028,748	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	150,891	126,011	276,902	-47,142	229,760	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	429,354	413,860	843,214	0	843,214	54.00
60.00	06000	LABORATORY	473,757	669,687	1,143,444	-26,633	1,116,811	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	26,633	26,633	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	204,131	59,873	264,004	-16,088	247,916	65.00
66.00	06600	PHYSICAL THERAPY	282,645	115,337	397,982	-74,052	323,930	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	69,374	69,374	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,665	4,665	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	63,127	63,127	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,204	17,204	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	227,727	890,757	1,118,484	-521,639	596,845	73.00
76.00	03950	SLEEP LAB	16,349	4,087	20,436	-419	20,017	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,919,898	476,835	2,396,733	-198,240	2,198,493	88.00
91.00	09100	EMERGENCY	768,830	1,804,260	2,573,090	-4,507	2,568,583	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		224,373	224,373	0	224,373	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,179,834	11,330,196	17,510,030	-640,679	16,869,351	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	384,117	139,987	524,104	119,040	643,144	192.00
194.00	07950	RETAIL PHARMACY	0	0	0	521,639	521,639	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	6,563,951	11,470,183	18,034,134	0	18,034,134	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1304

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

Worksheet A

Date/Time Prepared:
11/18/2021 8:01 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	0	830,390	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-61	375,929	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-143,347	625,728	4.00
5.01	00570	ADMITTING	0	144,232	5.01
5.02	00590	HOSPITAL ONLY A & G	-3,308	201,849	5.02
5.03	00591	SHARED ADMN & GENERAL	-929,564	3,048,815	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	535,330	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	28,183	8.00
9.00	00900	HOUSEKEEPING	0	199,922	9.00
10.00	01000	DIETARY	0	48	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,394	1,394	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,186	53,299	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	203,198	203,198	16.00
17.00	01700	SOCIAL SERVICE	11,710	53,336	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	144,213	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,028,748	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	229,760	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-312	842,902	54.00
60.00	06000	LABORATORY	0	1,116,811	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	26,633	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-19,096	228,820	65.00
66.00	06600	PHYSICAL THERAPY	-3,706	320,224	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	69,374	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,665	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	63,127	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17,204	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-276	596,569	73.00
76.00	03950	SLEEP LAB	0	20,017	76.00
76.01	03951	DIABETIC EDUCATION	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-60,780	2,137,713	88.00
91.00	09100	EMERGENCY	-182,946	2,385,637	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-224,373	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,335,281	15,534,070	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	-220,283	422,861	192.00
194.00	07950	RETAIL PHARMACY	0	521,639	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	194.01
194.02	07952	KIDNEY CENTER	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,555,564	16,478,570	200.00

RECLASSIFICATIONS

Provider CCN: 14-1304

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

Worksheet A-6

Date/Time Prepared:
11/18/2021 8:01 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RHC SALARY					
1.00	SHARED ADMN & GENERAL	5.03	185,298	12,942		1.00
	TOTALS		185,298	12,942		
	B - BLOOD					
1.00	BLOOD STORING PROCESSING & TRANS.	63.00	4,616	22,017		1.00
	TOTALS		4,616	22,017		
	C - COST OF IMPLANTS & MEDICAL SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	17,204		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	80,331		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
	TOTALS		0	97,535		
	E - RETAIL PHARMACY					
1.00	RETAIL PHARMACY	194.00	99,216	422,423		1.00
	TOTALS		99,216	422,423		
	F - CRNA					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	0	119,040		1.00
	TOTALS		0	119,040		
	G - THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	49,269	20,105		1.00
2.00	SPEECH PATHOLOGY	68.00	3,313	1,352		2.00
	TOTALS		52,582	21,457		
	I - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	36,795		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	36,795		
500.00	Grand Total: Increases		341,712	732,209		500.00

RECLASSIFICATIONS

Provider CCN: 14-1304

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

Worksheet A-6

Date/Time Prepared:
11/18/2021 8:01 am

	Decreases						11/18/2021 8:01 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RHC SALARY						
1.00	RURAL HEALTH CLINIC	88.00	185,298	12,942	0		1.00
	TOTALS		185,298	12,942			
	B - BLOOD						
1.00	LABORATORY	60.00	4,616	22,017	0		1.00
	TOTALS		4,616	22,017			
	C - COST OF IMPLANTS & MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	17,204	0		1.00
	PATIENT						
2.00	ADULTS & PEDIATRICS	30.00	0	12,162	0		2.00
3.00	OPERATING ROOM	50.00	0	47,142	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	16,088	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	13	0		5.00
6.00	SLEEP LAB	76.00	0	419	0		6.00
7.00	EMERGENCY	91.00	0	4,507	0		7.00
	TOTALS		0	97,535			
	E - RETAIL PHARMACY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	99,216	422,423	0		1.00
	TOTALS		99,216	422,423			
	F - CRNA						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	119,040	0		1.00
	TOTALS		0	119,040			
	G - THERAPY						
1.00	PHYSICAL THERAPY	66.00	52,582	21,457	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		52,582	21,457			
	I - PROPERTY INSURANCE						
1.00	SHARED ADMN & GENERAL	5.03	0	36,795	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	36,795			
500.00	Grand Total: Decreases		341,712	732,209			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/18/2021 8:01 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
			1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	65,000	0	0	0	0	1.00	
2.00	Land Improvements	326,868	1,100	0	1,100	0	2.00	
3.00	Buildings and Fixtures	13,033,780	180,730	0	180,730	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	3,218,633	476,397	0	476,397	0	5.00	
6.00	Movable Equipment	109,793	0	0	0	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	16,754,074	658,227	0	658,227	0	8.00	
9.00	Reconciling Items	-630,751	-28,727	0	-28,727	0	9.00	
10.00	Total (line 8 minus line 9)	17,384,825	686,954	0	686,954	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	65,000	0					1.00
2.00	Land Improvements	327,968	0					2.00
3.00	Buildings and Fixtures	13,214,510	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	3,695,030	0					5.00
6.00	Movable Equipment	109,793	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	17,412,301	0					8.00
9.00	Reconciling Items	-659,478	0					9.00
10.00	Total (line 8 minus line 9)	18,071,779	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/18/2021 8:01 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	793,827	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	375,758	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,169,585	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	793,827				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	375,758				2.00
3.00	Total (sum of lines 1-2)	0	1,169,585				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/18/2021 8:01 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	17,302,508	0	17,302,508	0.993695	36,563	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	109,793	0	109,793	0.006305	232	2.00
3.00	Total (sum of lines 1-2)	17,412,301	0	17,412,301	1.000000	36,795	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	36,563	793,827	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	232	375,697	0	2.00
3.00	Total (sum of lines 1-2)	0	0	36,795	1,169,524	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)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	36,563	0	0	830,390	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	232	0	0	375,929	2.00
3.00	Total (sum of lines 1-2)	0	36,795	0	0	1,206,319	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1304

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

Worksheet A-8

Date/Time Prepared:
11/18/2021 8:01 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				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-634	SHARED ADMN & GENERAL	5.03	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		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	-201,743			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	-330,001			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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	B	-41	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	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	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1304

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

Worksheet A-8

Date/Time Prepared:
11/18/2021 8:01 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.00 MISC INCOME - EMPLOYEE BENEFITS	B	-150	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01 MISC INCOME - A&G	B	-35,326	SHARED ADMN & GENERAL	5.03	0	33.01
33.02 MISC INCOME - RHC	B	-58,680	RURAL HEALTH CLINIC	88.00	0	33.02
34.00 PATIENT PHONES - DEPRECIATION	A	-61	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.00
34.01 PATIENT PHONES - SALARY	A	-639	RURAL HEALTH CLINIC	88.00	0	34.01
34.02 PATIENT PHONES - BENEFITS	A	-75	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.02
34.03 PATIENT PHONES - COSTS	A	-54	SHARED ADMN & GENERAL	5.03	0	34.03
35.00 ADVERTISING	A	-35,298	SHARED ADMN & GENERAL	5.03	0	35.00
35.01 ADVERTISING	A	-312	RADIOLOGY-DIAGNOSTIC	54.00	0	35.01
35.02 ADVERTISING	A	-3,706	PHYSICAL THERAPY	66.00	0	35.02
35.03 ADVERTISING	A	-235	DRUGS CHARGED TO PATIENTS	73.00	0	35.03
35.04 ADVERTISING	A	-1,461	RURAL HEALTH CLINIC	88.00	0	35.04
35.05 ADVERTISING	A	-299	EMERGENCY	91.00	0	35.05
35.06 ADVERTISING	A	-973	PHYSICIANS PRIVATE OFFICES	192.00	0	35.06
36.00 PROVIDER TAX ASSESSMENT	A	-422,092	SHARED ADMN & GENERAL	5.03	0	36.00
36.01 PHYSICIAN PRACTICE OVERHEAD	A	-93,474	SHARED ADMN & GENERAL	5.03	0	36.01
37.00 LOBBYING PORTION OF DUES	A	-5,826	SHARED ADMN & GENERAL	5.03	0	37.00
38.00 EMPLOYEE HEALTH INSURANCE	A	-143,122	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00 PROFESSIONAL FEES OFFSET 100% PART B	A	-219,310	PHYSICIANS PRIVATE OFFICES	192.00	0	39.00
40.00 INTEREST EXPENSE	A	-2,052	INTEREST EXPENSE	113.00	0	40.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,555,564				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-1304

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

Worksheet A-8-1

Date/Time Prepared:
11/18/2021 8:01 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.03	SHARED ADMN & GENERAL	HOME OFFICE - ADMIN LEGAL	186	0	1.00
2.00	5.03	SHARED ADMN & GENERAL	HOME OFFICE - IT	175,964	929,468	2.00
3.00	5.02	HOSPITAL ONLY A & G	HOME OFFICE - SBS PATIENT AC	201,728	205,036	3.00
4.00	5.03	SHARED ADMN & GENERAL	HOME OFFICE - SBS PATIENT AC	185,911	0	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE - TRANSCRIPTION	203,198	0	4.01
4.02	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE - CENTRAL SUPPLY	16,186	0	4.02
4.03	5.03	SHARED ADMN & GENERAL	HOME OFFICE - MEDICAL AFFAIR	18,720	0	4.03
4.04	17.00	SOCIAL SERVICE	HOME OFFICE - PASTORAL CARE	11,710	0	4.04
4.05	5.03	SHARED ADMN & GENERAL	HOME OFFICE - PAYOR CONTRACT	7,529	0	4.05
4.06	13.00	NURSING ADMINISTRATION	HOME OFFICE - CARE COORDINAT	1,394	0	4.06
4.07	5.03	SHARED ADMN & GENERAL	HOME OFFICE - PHYSICIAN RECR	4,181	0	4.07
4.08	5.03	SHARED ADMN & GENERAL	HOME OFFICE - LIBRARY	5,698	0	4.08
4.09	5.03	SHARED ADMN & GENERAL	HOME OFFICE - AFFILIATE FACI	150,877	0	4.09
4.10	5.03	SHARED ADMN & GENERAL	HOME OFFICE POOLED - CAPITAL	338,698	0	4.10
4.11	5.03	SHARED ADMN & GENERAL	HOME OFFICE POOLED - NON-CAP	934,673	1,229,829	4.11
4.12	6.00	MAINTENANCE & REPAIRS	VARIOUS SERVICES - RELATED	19,643	19,643	4.12
4.13	30.00	ADULTS & PEDIATRICS	VARIOUS SERVICES - RELATED	11,436	11,436	4.13
4.14	50.00	OPERATING ROOM	VARIOUS SERVICES - RELATED	1,734	1,734	4.14
4.15	54.00	RADIOLOGY-DIAGNOSTIC	VARIOUS SERVICES - RELATED	2,740	2,740	4.15
4.16	60.00	LABORATORY	VARIOUS SERVICES - RELATED	85,477	85,477	4.16
4.17	65.00	RESPIRATORY THERAPY	VARIOUS SERVICES - RELATED	4,250	4,250	4.17
4.18	66.00	PHYSICAL THERAPY	VARIOUS SERVICES - RELATED	599	599	4.18
4.19	73.00	DRUGS CHARGED TO PATIENTS	VARIOUS SERVICES - RELATED	220,215	220,215	4.19
4.20	88.00	RURAL HEALTH CLINIC	VARIOUS SERVICES - RELATED	2,400	2,400	4.20
4.21	91.00	EMERGENCY	VARIOUS SERVICES - RELATED	10,208	10,208	4.21
4.22	192.00	PHYSICIANS PRIVATE OFFICES	VARIOUS SERVICES - RELATED	2,184	2,184	4.22
4.23	113.00	INTEREST EXPENSE	INTEREST EXPENSE - RELATED	0	222,321	4.23
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,617,539	2,947,540	5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	B	GMC ALEDO	100.00	GENESIS HLTH SY	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-1304

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

Worksheet A-8-1

Date/Time Prepared:
11/18/2021 8:01 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	186	0		1.00
2.00	-753,504	0		2.00
3.00	-3,308	0		3.00
4.00	185,911	0		4.00
4.01	203,198	0		4.01
4.02	16,186	0		4.02
4.03	18,720	0		4.03
4.04	11,710	0		4.04
4.05	7,529	0		4.05
4.06	1,394	0		4.06
4.07	4,181	0		4.07
4.08	5,698	0		4.08
4.09	150,877	0		4.09
4.10	338,698	0		4.10
4.11	-295,156	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.23	-222,321	0		4.23
5.00	-330,001			5.00

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

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

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

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

6.00	NOT-FOR PROFIT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1304

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

Worksheet A-8-2

Date/Time Prepared:
11/18/2021 8:01 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	65.00	RESPIRATORY THERAPY	19,096	19,096	0	0	0	1.00
2.00	91.00	EMERGENCY	1,678,745	182,647	1,496,098	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,697,841	201,743	1,496,098			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	65.00	RESPIRATORY THERAPY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	65.00	RESPIRATORY THERAPY	0	0	0	19,096		1.00
2.00	91.00	EMERGENCY	0	0	0	182,647		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	201,743		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1304		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/18/2021 8:01 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					46	1.00
2.00	Line 1 multiplied by 15 hours per week					690	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					213	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.68	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,285.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	81.06	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.53	40.53	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					104,162	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					104,162	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					104,162	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					104,162	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					8,633	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					8,633	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,210	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					9,843	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					9,843	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					1,210	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1304		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/18/2021 8:01 am	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	81.06	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					104,162	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					9,843	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					114,005	63.00
64.00	Total cost of outside supplier services (from your records)					69,375	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					8,633	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,210	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					9,843	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,210	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					1,210	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
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11/18/2021 8:01 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	830,390	830,390			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	375,929		375,929		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	625,728	0	0	625,728	4.00
5.01	00570	ADMITTING	144,232	0	0	12,596	156,828
5.02	00590	HOSPITAL ONLY A & G	201,849	975	0	0	0
5.03	00591	SHARED ADMN & GENERAL	3,048,815	167,287	26,123	72,044	0
6.00	00600	MAINTENANCE & REPAIRS	535,330	76,300	6,019	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	28,183	2,263	0	2,520	0
9.00	00900	HOUSEKEEPING	199,922	10,930	0	0	0
10.00	01000	DIETARY	48	34,600	1,787	0	0
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,394	1,758	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	53,299	29,152	4,525	1,820	0
16.00	01600	MEDICAL RECORDS & LIBRARY	203,198	3,794	0	0	0
17.00	01700	SOCIAL SERVICE	53,336	2,611	0	3,485	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	144,213	975	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,028,748	161,372	23,283	84,086	12,197
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	229,760	88,100	97,809	14,508	9,391
54.00	05400	RADIOLOGY-DIAGNOSTIC	842,902	75,795	135,037	41,281	44,568
60.00	06000	LABORATORY	1,116,811	29,483	4,105	45,106	36,201
63.00	06300	BLOOD STORING PROCESSING & TRANS.	26,633	0	0	444	356
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	228,820	5,535	7,431	19,627	4,746
66.00	06600	PHYSICAL THERAPY	320,224	33,660	6,575	22,120	9,290
67.00	06700	OCCUPATIONAL THERAPY	69,374	7,205	1,408	4,737	1,482
68.00	06800	SPEECH PATHOLOGY	4,665	487	95	319	53
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	63,127	0	0	0	2,101
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,204	0	0	0	430
73.00	07300	DRUGS CHARGED TO PATIENTS	596,569	10,303	4,891	12,356	12,559
76.00	03950	SLEEP LAB	20,017	14,707	2,648	1,572	1,150
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,137,713	0	2,653	166,715	0
91.00	09100	EMERGENCY	2,385,637	41,283	45,269	73,921	22,304
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,534,070	798,575	369,658	579,257	156,828
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	4,473	0	0	0
192.00	19200	PHYSICIANS PRIVATE OFFICES	422,861	0	4,800	36,932	0
194.00	07950	RETAIL PHARMACY	521,639	0	1,471	9,539	0
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0
194.02	07952	KIDNEY CENTER	0	27,342	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		TOTAL (sum lines 118 through 201)	16,478,570	830,390	375,929	625,728	156,828

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
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Cost Center Description			Subtotal	HOSPITAL ONLY A & G	Subtotal	SHARED ADMN & GENERAL	MAINTENANCE & REPAIRS	
			5A.01	5.02	5A.02	5.03	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G	202,824	202,824				5.02
5.03	00591	SHARED ADMN & GENERAL	3,314,269	51,947	3,366,216	3,366,216		5.03
6.00	00600	MAINTENANCE & REPAIRS	617,649	9,682	627,331	161,385	788,716	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	32,966	517	33,483	8,614	3,046	8.00
9.00	00900	HOUSEKEEPING	210,852	3,305	214,157	55,093	14,715	9.00
10.00	01000	DIETARY	36,435	571	37,006	9,520	46,583	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,152	49	3,201	823	2,367	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	88,796	1,392	90,188	23,201	39,248	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	206,992	3,245	210,237	54,085	5,108	16.00
17.00	01700	SOCIAL SERVICE	59,432	932	60,364	15,529	3,515	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	145,188	2,276	147,464	37,936	1,312	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,309,686	20,529	1,330,215	342,207	217,260	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	439,568	6,890	446,458	114,854	118,612	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,139,583	17,863	1,157,446	297,761	102,046	54.00
60.00	06000	LABORATORY	1,231,706	19,307	1,251,013	321,832	39,694	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	27,433	430	27,863	7,168	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	266,159	4,172	270,331	69,545	7,451	65.00
66.00	06600	PHYSICAL THERAPY	391,869	6,143	398,012	102,391	45,317	66.00
67.00	06700	OCCUPATIONAL THERAPY	84,206	1,320	85,526	22,002	9,701	67.00
68.00	06800	SPEECH PATHOLOGY	5,619	88	5,707	1,468	656	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	65,228	1,022	66,250	17,043	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,634	276	17,910	4,607	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	636,678	9,980	646,658	166,357	13,872	73.00
76.00	03950	SLEEP LAB	40,094	628	40,722	10,476	19,800	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,307,081	0	2,307,081	593,513	0	88.00
91.00	09100	EMERGENCY	2,568,414	40,260	2,608,674	671,107	55,580	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,449,513	202,824	15,449,513	3,108,517	745,883	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	4,473	0	4,473	1,151	6,022	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	464,593	0	464,593	119,520	0	192.00
194.00	07950	RETAIL PHARMACY	532,649	0	532,649	137,028	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	27,342	0	27,342	0	36,811	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)	16,478,570	202,824	16,478,570	3,366,216	788,716	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1304

Period:
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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	45,143					8.00
9.00	00900	HOUSEKEEPING	0	283,965				9.00
10.00	01000	DIETARY	0	17,158	110,267			10.00
11.00	01100	CAFETERIA	0	0	7,378	7,378		11.00
13.00	01300	NURSING ADMINISTRATION	0	872	0	0	7,263	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,456	0	39	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,881	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,295	0	59	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	483	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,803	80,023	102,889	1,387	3,935	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,981	43,688	0	204	622	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,050	37,586	0	623	2	54.00
60.00	06000	LABORATORY	0	14,620	0	913	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	9	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,745	0	277	0	65.00
66.00	06600	PHYSICAL THERAPY	683	16,692	0	329	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	146	3,573	0	70	0	67.00
68.00	06800	SPEECH PATHOLOGY	9	242	0	5	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,109	0	128	0	73.00
76.00	03950	SLEEP LAB	0	7,293	0	26	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	430	0	0	1,681	0	88.00
91.00	09100	EMERGENCY	16,041	20,472	0	952	2,704	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,143	268,188	110,267	6,702	7,263	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	2,218	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	592	0	192.00
194.00	07950	RETAIL PHARMACY	0	0	0	84	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	13,559	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	45,143	283,965	110,267	7,378	7,263	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1304

Period:
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To 06/30/2021Worksheet B
Part I
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Cost Center Description			CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	16.00	17.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	167,132					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	271,311				16.00
17.00	01700	SOCIAL SERVICE	0	0	80,762			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	187,195		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,156	21,099	80,762	0	2,214,736	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,106	16,247	0	187,195	945,967	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,672	77,105	0	0	1,703,291	54.00
60.00	06000	LABORATORY	10,706	62,626	0	0	1,701,404	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	616	0	0	35,656	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,366	8,211	0	0	360,926	65.00
66.00	06600	PHYSICAL THERAPY	3,632	16,072	0	0	583,128	66.00
67.00	06700	OCCUPATIONAL THERAPY	778	2,564	0	0	124,360	67.00
68.00	06800	SPEECH PATHOLOGY	52	91	0	0	8,230	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	42,726	3,635	0	0	129,654	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,646	744	0	0	34,907	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,223	21,726	0	0	855,073	73.00
76.00	03950	SLEEP LAB	1,296	1,990	0	0	81,603	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	7,212	0	0	0	2,909,917	88.00
91.00	09100	EMERGENCY	24,296	38,585	0	0	3,438,411	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	161,867	271,311	80,762	187,195	15,127,263	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	13,864	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	5,265	0	0	0	589,970	192.00
194.00	07950	RETAIL PHARMACY	0	0	0	0	669,761	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	0	0	0	77,712	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)	167,132	271,311	80,762	187,195	16,478,570	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/18/2021 8:01 am

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00590	HOSPITAL ONLY A & G			5.02
5.03	00591	SHARED ADMN & GENERAL			5.03
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-196,241	2,018,495	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	945,967	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,703,291	54.00
60.00	06000	LABORATORY	0	1,701,404	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	35,656	63.00
64.00	06400	INTRAVENOUS THERAPY	188,067	188,067	64.00
65.00	06500	RESPIRATORY THERAPY	0	360,926	65.00
66.00	06600	PHYSICAL THERAPY	0	583,128	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	124,360	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,230	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	129,654	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	34,907	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	855,073	73.00
76.00	03950	SLEEP LAB	0	81,603	76.00
76.01	03951	DIABETIC EDUCATION	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	2,909,917	88.00
91.00	09100	EMERGENCY	8,174	3,446,585	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	15,127,263	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	13,864	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	589,970	192.00
194.00	07950	RETAIL PHARMACY	0	669,761	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	194.01
194.02	07952	KIDNEY CENTER	0	77,712	194.02
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	16,478,570	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01	00570	ADMITTING	0	0	0	0	5.01
5.02	00590	HOSPITAL ONLY A & G	0	975	0	975	5.02
5.03	00591	SHARED ADMN & GENERAL	359,317	167,287	26,123	552,727	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	76,300	6,019	82,319	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,263	0	2,263	8.00
9.00	00900	HOUSEKEEPING	0	10,930	0	10,930	9.00
10.00	01000	DIETARY	0	34,600	1,787	36,387	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,758	0	1,758	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	29,152	4,525	33,677	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,794	0	3,794	16.00
17.00	01700	SOCIAL SERVICE	0	2,611	0	2,611	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	975	0	975	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	161,372	23,283	184,655	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	88,100	97,809	185,909	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	75,795	135,037	210,832	54.00
60.00	06000	LABORATORY	0	29,483	4,105	33,588	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,535	7,431	12,966	65.00
66.00	06600	PHYSICAL THERAPY	0	33,660	6,575	40,235	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,205	1,408	8,613	67.00
68.00	06800	SPEECH PATHOLOGY	0	487	95	582	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,303	4,891	15,194	73.00
76.00	03950	SLEEP LAB	0	14,707	2,648	17,355	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	67,027	0	2,653	69,680	88.00
91.00	09100	EMERGENCY	0	41,283	45,269	86,552	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	426,344	798,575	369,658	1,594,577	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	4,473	0	4,473	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	31,350	0	4,800	36,150	192.00
194.00	07950	RETAIL PHARMACY	0	0	1,471	1,471	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	27,342	0	27,342	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	457,694	830,390	375,929	1,664,013	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			ADMITTING	HOSPITAL ONLY A & G	SHARED ADMN & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	6.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	0					5.01
5.02	00590	HOSPITAL ONLY A & G	0	975				5.02
5.03	00591	SHARED ADMN & GENERAL	0	255	552,982			5.03
6.00	00600	MAINTENANCE & REPAIRS	0	46	26,512	108,877		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2	1,415	420	4,100	8.00
9.00	00900	HOUSEKEEPING	0	16	9,050	2,031	0	9.00
10.00	01000	DIETARY	0	3	1,564	6,430	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	135	327	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7	3,811	5,418	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16	8,885	705	0	16.00
17.00	01700	SOCIAL SERVICE	0	4	2,551	485	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	11	6,232	181	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	98	56,216	29,992	1,798	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	33	18,868	16,374	271	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	85	48,915	14,087	459	54.00
60.00	06000	LABORATORY	0	92	52,869	5,479	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	2	1,178	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	20	11,424	1,029	0	65.00
66.00	06600	PHYSICAL THERAPY	0	29	16,820	6,256	62	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6	3,614	1,339	13	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	241	91	1	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5	2,800	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1	757	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48	27,328	1,915	0	73.00
76.00	03950	SLEEP LAB	0	3	1,721	2,733	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	97,500	0	39	88.00
91.00	09100	EMERGENCY	0	193	110,243	7,672	1,457	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	975	510,649	102,964	4,100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	189	831	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	19,634	0	0	192.00
194.00	07950	RETAIL PHARMACY	0	0	22,510	0	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	0	0	5,082	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)	0	975	552,982	108,877	4,100	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/18/2021 8:01 am

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	22,027					9.00
10.00	01000	DIETARY	1,331	45,715				10.00
11.00	01100	CAFETERIA	0	3,059	3,059			11.00
13.00	01300	NURSING ADMINISTRATION	68	0	0	2,288		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,121	0	16	0	44,050	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	146	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	100	0	25	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	37	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,207	42,656	575	1,239	3,995	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,389	0	85	196	3,981	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,916	0	258	1	6,766	54.00
60.00	06000	LABORATORY	1,134	0	378	0	2,822	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	4	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	213	0	115	0	624	65.00
66.00	06600	PHYSICAL THERAPY	1,295	0	136	0	957	66.00
67.00	06700	OCCUPATIONAL THERAPY	277	0	29	0	205	67.00
68.00	06800	SPEECH PATHOLOGY	19	0	2	0	14	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	11,260	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,070	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	396	0	53	0	322	73.00
76.00	03950	SLEEP LAB	566	0	11	0	342	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	696	0	1,901	88.00
91.00	09100	EMERGENCY	1,588	0	395	852	6,403	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,803	45,715	2,778	2,288	42,662	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	172	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	246	0	1,388	192.00
194.00	07950	RETAIL PHARMACY	0	0	35	0	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	1,052	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	22,027	45,715	3,059	2,288	44,050	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/18/2021 8:01 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,546					16.00
17.00	01700	SOCIAL SERVICE	0	5,776				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	7,436			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,053	5,776		334,260	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	811	0		229,917	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,854	0		288,173	0	54.00
60.00	06000	LABORATORY	3,125	0		99,487	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	31	0		1,215	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		0	0	64.00
65.00	06500	RESPIRATORY THERAPY	410	0		26,801	0	65.00
66.00	06600	PHYSICAL THERAPY	802	0		66,592	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	128	0		14,224	0	67.00
68.00	06800	SPEECH PATHOLOGY	5	0		955	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	181	0		14,246	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37	0		3,865	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,084	0		46,340	0	73.00
76.00	03950	SLEEP LAB	99	0		22,830	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0		0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0		169,816	0	88.00
91.00	09100	EMERGENCY	1,926	0		217,281	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,546	5,776	0	1,536,002	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		5,665	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		57,418	0	192.00
194.00	07950	RETAIL PHARMACY	0	0		24,016	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0		0	0	194.01
194.02	07952	KIDNEY CENTER	0	0		33,476	0	194.02
200.00		Cross Foot Adjustments			7,436	7,436	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,546	5,776	7,436	1,664,013	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/18/2021 8:01 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00570	ADMITTING	5.01
5.02	00590	HOSPITAL ONLY A & G	5.02
5.03	00591	SHARED ADMN & GENERAL	5.03
6.00	00600	MAINTENANCE & REPAIRS	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	63.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	SLEEP LAB	76.00
76.01	03951	DIABETIC EDUCATION	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
194.00	07950	RETAIL PHARMACY	194.00
194.01	07951	NONPATIENT RELATED MEALS	194.01
194.02	07952	KIDNEY CENTER	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1304

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

Worksheet B-1

Date/Time Prepared:
11/18/2021 8:01 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	47,712					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		375,697				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,508,033			4.00
5.01	00570	ADMITTING	0	0	131,008	22,831,077		5.01
5.02	00590	HOSPITAL ONLY A & G	56	0	0	0	-202,824	5.02
5.03	00591	SHARED ADMN & GENERAL	9,612	26,107	749,309	0	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	4,384	6,015	0	0	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	130	0	26,212	0	0	8.00
9.00	00900	HOUSEKEEPING	628	0	0	0	0	9.00
10.00	01000	DIETARY	1,988	1,786	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	101	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,675	4,522	18,933	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	218	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	150	0	36,248	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	56	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,272	23,269	874,561	1,775,590	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,062	97,749	150,891	1,367,208	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,355	134,955	429,354	6,487,843	0	54.00
60.00	06000	LABORATORY	1,694	4,102	469,141	5,270,217	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	4,616	51,858	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	318	7,426	204,131	690,979	0	65.00
66.00	06600	PHYSICAL THERAPY	1,934	6,571	230,063	1,352,499	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	414	1,407	49,269	215,779	0	67.00
68.00	06800	SPEECH PATHOLOGY	28	95	3,313	7,695	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	305,894	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	62,621	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	592	4,888	128,511	1,828,360	0	73.00
76.00	03950	SLEEP LAB	845	2,646	16,349	167,447	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	2,651	1,733,961	0	-2,307,081	88.00
91.00	09100	EMERGENCY	2,372	45,241	768,830	3,247,087	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,884	369,430	6,024,700	22,831,077	-2,509,905	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	257	0	0	0	-4,473	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	4,797	384,117	0	-464,593	192.00
194.00	07950	RETAIL PHARMACY	0	1,470	99,216	0	-532,649	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	1,571	0	0	0	-27,342	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)	830,390	375,929	625,728	156,828		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.404217	1.000618	0.096147	0.006869		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1304

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

Worksheet B-1

Date/Time Prepared:
11/18/2021 8:01 am

Cost Center Description		HOSPITAL ONLY A & G (ACCUM. COST)	Reconciliation	SHARED ADMN & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5.02	5A.03	5.03	6.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00590	HOSPITAL ONLY A & G	12,939,608				5.02
5.03	00591	SHARED ADMN & GENERAL	3,314,269	-3,366,216	13,085,012		5.03
6.00	00600	MAINTENANCE & REPAIRS	617,649	0	627,331	33,660	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	32,966	0	33,483	130	8.00
9.00	00900	HOUSEKEEPING	210,852	0	214,157	628	9.00
10.00	01000	DIETARY	36,435	0	37,006	1,988	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,152	0	3,201	101	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	88,796	0	90,188	1,675	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	206,992	0	210,237	218	16.00
17.00	01700	SOCIAL SERVICE	59,432	0	60,364	150	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	145,188	0	147,464	56	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,309,686	0	1,330,215	9,272	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	439,568	0	446,458	5,062	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,139,583	0	1,157,446	4,355	54.00
60.00	06000	LABORATORY	1,231,706	0	1,251,013	1,694	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	27,433	0	27,863	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	266,159	0	270,331	318	65.00
66.00	06600	PHYSICAL THERAPY	391,869	0	398,012	1,934	66.00
67.00	06700	OCCUPATIONAL THERAPY	84,206	0	85,526	414	67.00
68.00	06800	SPEECH PATHOLOGY	5,619	0	5,707	28	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	65,228	0	66,250	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,634	0	17,910	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	636,678	0	646,658	592	73.00
76.00	03950	SLEEP LAB	40,094	0	40,722	845	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	2,307,081	0	88.00
91.00	09100	EMERGENCY	2,568,414	0	2,608,674	2,372	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,939,608	-3,366,216	12,083,297	31,832	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	4,473	257	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	464,593	0	192.00
194.00	07950	RETAIL PHARMACY	0	0	532,649	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	-27,342	0	1,571	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)	202,824		3,366,216	788,716	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.015675		0.257257	23.431848	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	975		552,982	108,877	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000075		0.042261	3.234611	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: 14-1304

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

Worksheet B-1

Date/Time Prepared:
11/18/2021 8:01 am

Cost Center Description			HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	32,902					9.00
10.00	01000	DIETARY	1,988	4,319				10.00
11.00	01100	CAFETERIA	0	289	8,085			11.00
13.00	01300	NURSING ADMINISTRATION	101	0	0	53,537		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,675	0	43	0	246,885	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	218	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	150	0	65	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	56	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,272	4,030	1,520	29,002	22,388	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,062	0	224	4,583	22,314	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,355	0	683	18	37,923	54.00
60.00	06000	LABORATORY	1,694	0	1,000	0	15,815	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	10	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	318	0	304	0	3,495	65.00
66.00	06600	PHYSICAL THERAPY	1,934	0	360	0	5,365	66.00
67.00	06700	OCCUPATIONAL THERAPY	414	0	77	0	1,149	67.00
68.00	06800	SPEECH PATHOLOGY	28	0	5	0	77	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	63,114	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	17,204	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	592	0	140	0	1,806	73.00
76.00	03950	SLEEP LAB	845	0	29	0	1,914	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	1,841	0	10,654	88.00
91.00	09100	EMERGENCY	2,372	0	1,043	19,934	35,889	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,074	4,319	7,344	53,537	239,107	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	257	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	649	0	7,778	192.00
194.00	07950	RETAIL PHARMACY	0	0	92	0	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	1,571	0	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)	283,965	110,267	7,378	7,263	167,132	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.630630	25.530678	0.912554	0.135663	0.676963	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	22,027	45,715	3,059	2,288	44,050	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.669473	10.584626	0.378355	0.042737	0.178423	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: 14-1304

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

Worksheet B-1

Date/Time Prepared:
11/18/2021 8:01 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
			16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00590	HOSPITAL ONLY A & G				5.02
5.03	00591	SHARED ADMN & GENERAL				5.03
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,831,077			16.00
17.00	01700	SOCIAL SERVICE	0	1,352		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,775,590	1,352	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,367,208	0	100	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,487,843	0	0	54.00
60.00	06000	LABORATORY	5,270,217	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	51,858	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	690,979	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,352,499	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	215,779	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,695	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	305,894	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	62,621	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,828,360	0	0	73.00
76.00	03950	SLEEP LAB	167,447	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
91.00	09100	EMERGENCY	3,247,087	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,831,077	1,352	100	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	192.00
194.00	07950	RETAIL PHARMACY	0	0	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	194.01
194.02	07952	KIDNEY CENTER	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)	271,311	80,762	187,195	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.011883	59.735207	1,871.950000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	13,546	5,776	7,436	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000593	4.272189	74.360000	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: 14-1304

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

Worksheet B-2

Date/Time Prepared:
11/18/2021 8:01 am

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0 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	-196,241 7.00
8.00		IV THERAPY		1	64.00	188,067 8.00
9.00		EMERGENCY		1	91.00	8,174 9.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/18/2021 8:01 am

				Title XVIII	Hospital	Cost			
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance		Total Costs	
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,018,495		2,018,495	0		0	30.00
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	945,967		945,967	0		0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,703,291		1,703,291	0		0	54.00
60.00	06000	LABORATORY	1,701,404		1,701,404	0		0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	35,656		35,656	0		0	63.00
64.00	06400	INTRAVENOUS THERAPY	188,067		188,067	0		0	64.00
65.00	06500	RESPIRATORY THERAPY	360,926	0	360,926	0		0	65.00
66.00	06600	PHYSICAL THERAPY	583,128	0	583,128	0		0	66.00
67.00	06700	OCCUPATIONAL THERAPY	124,360	0	124,360	0		0	67.00
68.00	06800	SPEECH PATHOLOGY	8,230	0	8,230	0		0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	129,654		129,654	0		0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,907		34,907	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	855,073		855,073	0		0	73.00
76.00	03950	SLEEP LAB	81,603		81,603	0		0	76.00
76.01	03951	DIABETIC EDUCATION	0		0	0		0	76.01
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,909,917		2,909,917	0		0	88.00
91.00	09100	EMERGENCY	3,446,585		3,446,585	0		0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	446,538		446,538	0		0	92.00
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	15,573,801	0	15,573,801	0		0	200.00
201.00		Less Observation Beds	446,538		446,538				201.00
202.00		Total (see instructions)	15,127,263	0	15,127,263	0		0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/18/2021 8:01 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	880,787		880,787		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,367,208	1,367,208	0.691897	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	92,619	6,395,224	6,487,843	0.262536	0.000000
60.00	06000	LABORATORY	168,937	5,101,280	5,270,217	0.322834	0.000000
63.00	06300	BLOOD STORING PROCESSING & TRANS.	6,912	44,946	51,858	0.687570	0.000000
64.00	06400	INTRAVENOUS THERAPY	78,359	328,437	406,796	0.462313	0.000000
65.00	06500	RESPIRATORY THERAPY	127,686	563,293	690,979	0.522340	0.000000
66.00	06600	PHYSICAL THERAPY	160,344	1,192,155	1,352,499	0.431149	0.000000
67.00	06700	OCCUPATIONAL THERAPY	109,711	106,068	215,779	0.576330	0.000000
68.00	06800	SPEECH PATHOLOGY	555	7,140	7,695	1.069526	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	112,787	193,107	305,894	0.423853	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	62,621	62,621	0.557433	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	494,409	1,333,951	1,828,360	0.467672	0.000000
76.00	03950	SLEEP LAB	0	167,447	167,447	0.487336	0.000000
76.01	03951	DIABETIC EDUCATION	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,856,273	3,856,273		
91.00	09100	EMERGENCY	56,298	3,190,789	3,247,087	1.061439	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	18,774	469,233	488,007	0.915024	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	2,308,178	24,379,172	26,687,350		
201.00		Less Observation Beds					
202.00		Total (see instructions)	2,308,178	24,379,172	26,687,350		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/18/2021 8:01 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
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
63.00	06300 BLOOD STORING PROCESSING & TRANS.	0.000000			63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950 SLEEP LAB	0.000000			76.00
76.01	03951 DIABETIC EDUCATION	0.000000			76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
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				Title XIX		Hospital			
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	880,787		880,787			30.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,367,208	1,367,208	0.691897	0.000000	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	92,619	6,395,224	6,487,843	0.262536	0.000000	54.00	
60.00	06000	LABORATORY	168,937	5,101,280	5,270,217	0.322834	0.000000	60.00	
63.00	06300	BLOOD STORING PROCESSING & TRANS.	6,912	44,946	51,858	0.687570	0.000000	63.00	
64.00	06400	INTRAVENOUS THERAPY	78,359	328,437	406,796	0.462313	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	127,686	563,293	690,979	0.522340	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	160,344	1,192,155	1,352,499	0.431149	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	109,711	106,068	215,779	0.576330	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	555	7,140	7,695	1.069526	0.000000	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	112,787	193,107	305,894	0.423853	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	62,621	62,621	0.557433	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	494,409	1,333,951	1,828,360	0.467672	0.000000	73.00	
76.00	03950	SLEEP LAB	0	167,447	167,447	0.487336	0.000000	76.00	
76.01	03951	DIABETIC EDUCATION	0	0	0	0.000000	0.000000	76.01	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	3,856,273	3,856,273	0.754593	0.000000	88.00	
91.00	09100	EMERGENCY	56,298	3,190,789	3,247,087	1.061439	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	18,774	469,233	488,007	0.915024	0.000000	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	2,308,178	24,379,172	26,687,350			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	2,308,178	24,379,172	26,687,350			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/18/2021 8:01 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	
		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
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
63.00	06300 BLOOD STORING PROCESSING & TRANS.	0.000000			63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950 SLEEP LAB	0.000000			76.00
76.01	03951 DIABETIC EDUCATION	0.000000			76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/18/2021 8:01 am

Cost Center Description			Title XVIII		Hospital	Cost		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	229,917	1,367,208	0.168165	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	288,173	6,487,843	0.044417	31,577	1,403	54.00
60.00	06000	LABORATORY	99,487	5,270,217	0.018877	58,614	1,106	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	1,215	51,858	0.023429	2,299	54	63.00
64.00	06400	INTRAVENOUS THERAPY	0	406,796	0.000000	20,392	0	64.00
65.00	06500	RESPIRATORY THERAPY	26,801	690,979	0.038787	32,572	1,263	65.00
66.00	06600	PHYSICAL THERAPY	66,592	1,352,499	0.049236	3,715	183	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,224	215,779	0.065919	1,301	86	67.00
68.00	06800	SPEECH PATHOLOGY	955	7,695	0.124107	370	46	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,246	305,894	0.046572	31,405	1,463	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,865	62,621	0.061721	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	46,340	1,828,360	0.025345	203,929	5,169	73.00
76.00	03950	SLEEP LAB	22,830	167,447	0.136342	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0.000000	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	169,816	3,856,273	0.044036	0	0	88.00
91.00	09100	EMERGENCY	217,281	3,247,087	0.066916	24,082	1,611	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	73,946	488,007	0.151527	10,560	1,600	92.00
200.00		Total (lines 50 through 199)	1,275,688	25,806,563		420,816	13,984	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/18/2021 8:01 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	187,195	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03950	SLEEP LAB	0	0	0	0	0
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
200.00		Total (lines 50 through 199)	187,195	0	0	0	0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1304		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/18/2021 8:01 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	187,195	0	1,367,208	0.136918	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,487,843	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	5,270,217	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	51,858	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	406,796	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	690,979	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,352,499	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	215,779	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	7,695	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	305,894	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	62,621	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,828,360	0.000000	73.00
76.00	03950	SLEEP LAB	0	0	0	167,447	0.000000	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,856,273	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	3,247,087	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	488,007	0.000000	92.00
200.00		Total (lines 50 through 199)	0	187,195	0	25,806,563		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/18/2021 8:01 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	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	31,577	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	58,614	0	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.000000	2,299	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	20,392	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	32,572	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,715	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,301	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	370	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	31,405	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	203,929	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
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	24,082	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	10,560	0	0	0	92.00
200.00		Total (lines 50 through 199)		420,816	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/18/2021 8:01 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	0.691897	0	259,198	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.262536	0	1,844,646	0	0	54.00
60.00	06000	LABORATORY	0.322834	0	1,324,848	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.687570	0	16,987	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.462313	0	143,488	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.522340	0	168,481	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.431149	0	365,941	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.576330	0	52,949	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.069526	0	909	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.423853	0	65,148	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.557433	0	6,413	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.467672	0	475,608	0	0	73.00
76.00	03950	SLEEP LAB	0.487336	0	51,977	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.000000	0	0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	1.061439	0	910,845	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.915024	0	179,745	0	0	92.00
200.00		Subtotal (see instructions)		0	5,867,183	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	5,867,183	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-1304		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Prepared: 11/18/2021 8:01 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	179,338	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	484,286	0		54.00
60.00	06000	LABORATORY	427,706	0		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	11,680	0		63.00
64.00	06400	INTRAVENOUS THERAPY	66,336	0		64.00
65.00	06500	RESPIRATORY THERAPY	88,004	0		65.00
66.00	06600	PHYSICAL THERAPY	157,775	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	30,516	0		67.00
68.00	06800	SPEECH PATHOLOGY	972	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,613	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,575	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	222,429	0		73.00
76.00	03950	SLEEP LAB	25,330	0		76.00
76.01	03951	DIABETIC EDUCATION	0	0		76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	966,806	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	164,471	0		92.00
200.00		Subtotal (see instructions)	2,856,837	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,856,837	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1304	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/18/2021 8:01 am
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,124	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)		250	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		318	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)		269	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		26	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)		22	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		151	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)		208	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)		176	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		169.71	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		169.71	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,018,495	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)		4,412	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)		3,734	25.00
26.00	Total swing-bed cost (see instructions)		1,104,867	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		913,628	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)		913,628	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,868.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		282,121	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)		282,121	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1304	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/18/2021 8:01 am
Title XVIII			Hospital		Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					201,891 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					484,012 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)					388,617 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					328,830 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					717,447 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)					239 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,868.36 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					446,538 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1304

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

Worksheet D-1

Date/Time Prepared:
11/18/2021 8:01 am

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	334,260	2,018,495	0.165599	446,538	73,946
91.00	Nursing School cost	0	2,018,495	0.000000	446,538	0
92.00	Allied health cost	0	2,018,495	0.000000	446,538	0
93.00	All other Medical Education	0	2,018,495	0.000000	446,538	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1304	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/18/2021 8:01 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		165,770		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.691897	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.262536	31,577	8,290	54.00
60.00	06000 LABORATORY	0.322834	58,614	18,923	60.00
63.00	06300 BLOOD STORING PROCESSING & TRANS.	0.687570	2,299	1,581	63.00
64.00	06400 INTRAVENOUS THERAPY	0.462313	20,392	9,427	64.00
65.00	06500 RESPIRATORY THERAPY	0.522340	32,572	17,014	65.00
66.00	06600 PHYSICAL THERAPY	0.431149	3,715	1,602	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.576330	1,301	750	67.00
68.00	06800 SPEECH PATHOLOGY	1.069526	370	396	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.423853	31,405	13,311	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.557433	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.467672	203,929	95,372	73.00
76.00	03950 SLEEP LAB	0.487336	0	0	76.00
76.01	03951 DIABETIC EDUCATION	0.000000	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	1.061439	24,082	25,562	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.915024	10,560	9,663	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		420,816	201,891	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)		420,816		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1304 Component CCN: 14-Z304	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/18/2021 8:01 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	0.691897	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.262536	6,971	1,830	54.00
60.00	06000 LABORATORY	0.322834	34,302	11,074	60.00
63.00	06300 BLOOD STORING PROCESSING & TRANS.	0.687570	2,314	1,591	63.00
64.00	06400 INTRAVENOUS THERAPY	0.462313	21,762	10,061	64.00
65.00	06500 RESPIRATORY THERAPY	0.522340	25,505	13,322	65.00
66.00	06600 PHYSICAL THERAPY	0.431149	93,519	40,321	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.576330	63,674	36,697	67.00
68.00	06800 SPEECH PATHOLOGY	1.069526	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.423853	29,157	12,358	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.557433	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.467672	80,313	37,560	73.00
76.00	03950 SLEEP LAB	0.487336	0	0	76.00
76.01	03951 DIABETIC EDUCATION	0.000000	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	1.061439	10,276	10,907	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.915024	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		367,793	175,721	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)		367,793		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1304	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/18/2021 8:01 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,856,837	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,856,837	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)		2,885,405	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)		18,786	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		885,032	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,981,587	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,981,587	30.00
31.00	Primary payer payments		365	31.00
32.00	Subtotal (line 30 minus line 31)		1,981,222	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)		142,200	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		92,430	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		128,379	36.00
37.00	Subtotal (see instructions)		2,073,652	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,073,652	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		1,794,756	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)		278,896	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: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/18/2021 8:01 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		346,139		1,829,823	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	01/21/2021	19,002	01/21/2021	26,033	3.50
3.51		05/20/2021	12,967	05/20/2021	9,034	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)		-31,969		-35,067	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)		314,170		1,794,756	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		142,687		278,896	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		456,857		2,073,652	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: 14-1304
 Component CCN: 14-Z304

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 11/18/2021 8:01 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		738,015		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	01/21/2021	31,532		0	3.50
3.51		05/20/2021	15,939		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)		-47,471		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)		690,544		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		209,229		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		899,773		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: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/18/2021 8:01 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: 14-1304 Component CCN: 14-Z304	Period: From 07/01/2020 To 06/30/2021	Worksheet E-2 Date/Time Prepared: 11/18/2021 8:01 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)	724,621	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)	177,478	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	384	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)	902,099	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	902,099	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)	902,099	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,326	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	899,773	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	899,773	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	690,544	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)	209,229	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: 14-1304	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part V Date/Time Prepared: 11/18/2021 8:01 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		484,012	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)		484,012	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		488,852	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)		488,852	19.00
20.00	Deductibles (exclude professional component)		35,656	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		453,196	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		453,196	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		5,632	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		3,661	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		5,632	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		456,857	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)		456,857	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		314,170	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)		142,687	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: 14-1304

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

Worksheet G

Date/Time Prepared: 11/18/2021 8:01 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	110,546	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	4,427,520	0	0	0	4.00
5.00	Other receivable	10,473	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,157,730	0	0	0	6.00
7.00	Inventory	160,134	0	0	0	7.00
8.00	Prepaid expenses	379,586	0	0	0	8.00
9.00	Other current assets	905,788	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)	3,836,317	0	0	0	11.00
FIXED ASSETS						
12.00	Land	65,000	0	0	0	12.00
13.00	Land improvements	327,968	0	0	0	13.00
14.00	Accumulated depreciation	-183,743	0	0	0	14.00
15.00	Buildings	13,214,510	0	0	0	15.00
16.00	Accumulated depreciation	-4,934,211	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	3,695,030	0	0	0	19.00
20.00	Accumulated depreciation	-2,350,578	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	109,793	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	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	9,943,769	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,390,429	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	1,026,094	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,416,523	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	16,196,609	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	123,550	0	0	0	37.00
38.00	Salaries, wages, and fees payable	424,668	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,065,140	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	782,212	0	0	0	42.00
43.00	Due to other funds	2,553,871	0	0	0	43.00
44.00	Other current liabilities	423,543	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,372,984	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	3,259,920	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	3,013,251	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,273,171	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,646,155	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	4,550,454	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	4,550,454	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	16,196,609	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1304

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

Worksheet G-1

Date/Time Prepared:
11/18/2021 8:01 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		4,590,907		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		342,757				2.00
3.00	Total (sum of line 1 and line 2)		4,933,664		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		4,933,664		0		11.00
12.00	CHANGE IN PY FUND BALANCE	383,210		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		383,210		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		4,550,454		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	CHANGE IN PY FUND BALANCE		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1304

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/18/2021 8:01 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	383,189		383,189	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	456,849		456,849	5.00
6.00	Swing bed - NF	40,748		40,748	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)	880,786		880,786	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)	880,786		880,786	17.00
18.00	Ancillary services	1,352,319	17,127,872	18,480,191	18.00
19.00	Outpatient services	75,072	3,694,217	3,769,289	19.00
20.00	RURAL HEALTH CLINIC	0	3,856,273	3,856,273	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRIVATE OFFICES	0	1,516,862	1,516,862	27.00
27.01	RETAIL PHARMACY REVENUES	0	90,875	90,875	27.01
27.02	PROFESSIONAL CHARGES	23,901	1,541,318	1,565,219	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,332,078	27,827,417	30,159,495	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,034,134		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)		18,034,134		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1304

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

Worksheet G-3

Date/Time Prepared:
11/18/2021 8:01 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	30,159,495	1.00
2.00	Less contractual allowances and discounts on patients' accounts	13,595,493	2.00
3.00	Net patient revenues (line 1 minus line 2)	16,564,002	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	18,034,134	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,470,132	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	186,247	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	634	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	31,812	22.00
23.00	Governmental appropriations	-500	23.00
24.00	MISC REVENUE	65,582	24.00
24.01	RETAIL PHARMACY REVENUE	1,529,114	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,812,889	25.00
26.00	Total (line 5 plus line 25)	342,757	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	342,757	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1304

Period:

Worksheet M-1

Component CCN: 14-3453

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/18/2021 8:01 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	747,705	58,716	806,421	-3,730	802,691 1.00
2.00	Physician Assistant	96,701	7,594	104,295	0	104,295 2.00
3.00	Nurse Practitioner	395,287	31,041	426,328	-1,889	424,439 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	212,926	16,721	229,647	0	229,647 5.00
6.00	Clinical Psychologist	0	0	0	0	0 6.00
7.00	Clinical Social Worker	63,036	4,950	67,986	-1,533	66,453 7.00
8.00	Laboratory Technician	0	0	0	0	0 8.00
9.00	Other Facility Health Care Staff Costs	191,917	15,071	206,988	0	206,988 9.00
10.00	Subtotal (sum of lines 1 through 9)	1,707,572	134,093	1,841,665	-7,152	1,834,513 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	481	481	0	481 13.00
14.00	Subtotal (sum of lines 11 through 13)	0	481	481	0	481 14.00
15.00	Medical Supplies	0	10,654	10,654	22,088	32,742 15.00
16.00	Transportation (Health Care Staff)	0	164	164	0	164 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	486	486	0	486 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	11,304	11,304	22,088	33,392 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,707,572	145,878	1,853,450	14,936	1,868,386 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	22,791	22,791	-22,088	703 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	7,152	7,152 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	22,791	22,791	-14,936	7,855 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	83,985	83,985	0	83,985 29.00
30.00	Administrative Costs	212,326	224,181	436,507	-198,240	238,267 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	212,326	308,166	520,492	-198,240	322,252 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,919,898	476,835	2,396,733	-198,240	2,198,493 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1304

Period:

Worksheet M-1

Component CCN: 14-3453

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/18/2021 8:01 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	802,691	1.00
2.00	Physician Assistant	0	104,295	2.00
3.00	Nurse Practitioner	0	424,439	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	229,647	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	66,453	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	206,988	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,834,513	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	481	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	481	14.00
15.00	Medical Supplies	0	32,742	15.00
16.00	Transportation (Health Care Staff)	0	164	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	486	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	33,392	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,868,386	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	703	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	7,152	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	7,855	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	83,985	29.00
30.00	Administrative Costs	-60,780	177,487	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-60,780	261,472	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-60,780	2,137,713	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1304

Period:

Worksheet M-2

Component CCN: 14-3453

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/18/2021 8:01 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	2.14	7,102	4,200	8,988		1.00
2.00	Physician Assistant	0.74	1,950	2,100	1,554		2.00
3.00	Nurse Practitioner	2.45	8,538	2,100	5,145		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.33	17,590		15,687	17,590	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.75	1,691			1,691	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	6.08	19,281			19,281	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,868,386	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					7,855	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,876,241	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.995813	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					261,472	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					772,204	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,033,676	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,033,676	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,029,348	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,897,734	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1304 Component CCN: 14-3453	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/18/2021 8:01 am	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,897,734	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			44,272	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,853,462	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			19,281	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)			19,281	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			147.99	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	141.95	8.00
9.00	Rate for Program covered visits (see instructions)	147.99	147.99	141.95	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,370	877	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	350,736	124,490	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	2	1	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	296	142	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	296	142	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	475,664		16.00
16.01	Total program charges (see instructions)(from contractor's records)		702,286		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		43,538		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		29,489		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		302,803		16.04
16.05	Total program cost (see instructions)	0	332,292		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		67,671		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		118,216		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		332,292		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		18,363		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		350,655		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		350,655		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		306,593		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)		44,062		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: 14-1304

Period:

Worksheet M-4

Component CCN: 14-3453

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/18/2021 8:01 am

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,834,513	1,834,513	1,834,513	1,834,513	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000005	0.002753	0.000762	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	9	5,050	1,398	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	36	22,052	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	45	27,102	1,398	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,868,386	1,868,386	1,868,386	1,868,386	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,029,348	1,029,348	1,029,348	1,029,348	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000024	0.014506	0.000748	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	25	14,932	770	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	70	42,034	2,168	0	10.00
11.00	Total number of injections/infusions (from your records)	1	607	168	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	70.00	69.25	12.90	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	243	42	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			77	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)	0	16,828	1,535	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)		44,272			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		18,363			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1304 Component CCN: 14-3453	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/18/2021 8:01 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		304,188	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		01/21/2021	2,405	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)		2,405	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		306,593	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		44,062	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		350,655	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00