

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: 14-1305

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

Worksheet S
Parts I-III
Date/Time Prepared:
5/24/2022 8:35 am

PART I - COST REPORT STATUS

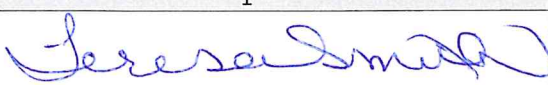
Provider use only	1. ☒ Electronically prepared cost report	Date: 5/24/2022	Time: 8:35 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL ASSOCIATION (14-1305) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
1		2	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	351,810	-1,010,530	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	118,350	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		120,705		0	10.00
200.00 Total	0	470,160	-889,825	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: 14-1305		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 8:35 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: SOUTH ADAMS STREET			PO Box: 160				1.00	
2.00	City: CARTHAGE			State: IL		Zip Code: 62321-		County: HANCOCK	
		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		MEMORIAL HOSPITAL ASSOCIATION	141305	99914	1	08/08/2000	N	O
4.00	Subprovider - IPF								P
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		MEMORIAL HOSPITAL	14Z305	99914		08/08/2000	N	O
8.00	Swing Beds - NF								N
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC		BOWEN CLINIC	143456	99914		02/05/1999	N	O
16.00	Hospital-Based Health Clinic - FQHC								N
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2021	12/31/2021	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N		

Worksheet S-2
Part I
Date/Time Prepared:
5/24/2022 8:35 am

MCRIF32 - 17.4.174.1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1305		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 8:35 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)					0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00
					0.000000	64.00	

Worksheet S-2
Part I
Date/Time Prepared:
5/24/2022 8:35 am

MCRIF32 - 17.4.174.1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA
Provider CCN: 14-1305
Period: From 01/01/2021 To 12/31/2021
Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 8:35 am

		1.00			
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	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.	N	N	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	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N			110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1305	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 8:35 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	169,577	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.	Y	5.01	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	H55770	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1305		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 8:35 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: UNITYPOINT HEALTH (IA HEALTH SYSTEM)		Contractor's Name: WPS		Contractor's Number: 05001				141.00		
142.00	Street: 1776 WEST LAKES PARKWAY SUITE 400		PO Box:						142.00		
143.00	City: WEST DES MOINES		State: IA		Zip Code:		50266-8239		143.00		
									1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00	
									1.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.									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			166.00	
									1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act											
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00	
						Beginning	Ending				
						1.00	2.00				
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00	
						1.00	2.00				
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1305	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/24/2022 8:35 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/21/2022	Y 03/21/2022
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
5/24/2022 8:35 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		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.		Y		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		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.		Y		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.	TERESA	SMITH		41.00
42.00	Enter the employer/company name of the cost report preparer.	MEMORIAL HOSPITAL ASSOCIATION			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-357-8564	TSMITH@MHTLC.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
5/24/2022 8:35 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.	CHIEF FINANCIAL OFFICER	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: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/24/2022 8:35 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	18	6,570	41,496.00	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)		18	6,570	41,496.00	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	43.00				0	13.00
14.00 Total (see instructions)		18	6,570	41,496.00	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	46.00	0	0			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		18				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: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/24/2022 8:35 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)	900	176	1,685			1.00
2.00	HMO and other (see instructions)	189	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	782	0	849			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	30			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,682	176	2,564			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		97	185			13.00
14.00	Total (see instructions)	1,682	273	2,749	0.00	163.29	14.00
15.00	CAH visits	8,445	5,293	23,690			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			0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	6,354	9,919	32,493	0.00	57.26	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	220.55	27.00
28.00	Observation Bed Days		52	253			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	21	44			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: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/24/2022 8:35 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	229	77	490	1.00
2.00 HMO and other (see instructions)			41	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	229	77	490	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	0.00				0	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1305 Component CCN: 14-3456		Period: From 01/01/2021 To 12/31/2021		Worksheet S-8 Date/Time Prepared: 5/24/2022 8:35 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County			IL				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	
9.01								9.01	
9.02								9.02	
9.03								9.03	
9.04								9.04	
9.05								9.05	
9.06								9.06	
9.07								9.07	
9.08								9.08	
9.09								9.09	
9.10								9.10	
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC			08:00		17:00		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.			Y		6		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number			BOWEN CLINIC		143456		14.00	
14.01				WOMEN & FAMILY MEDICAL GROUP CLINIC		143405		14.01	
14.02				LAHARPE CLINIC		148534		14.02	
14.03				NAUVOO CLINIC		148547		14.03	
14.04				CARTHAGE CLINIC		148571		14.04	
14.05				COLCHESTER CLINIC		148572		14.05	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1305

Period:

Worksheet S-8

Component CCN: 14-3456

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

Date/Time Prepared:

5/24/2022 8:35 am

		Y/N	V	XVIII	XIX	Total Visits	Cost
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)	1.00	2.00	3.00	4.00	5.00	15.00
		County					
2.00	City, State, ZIP Code, County	HANCOCK					2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)							
11.00	CLINIC	18:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
Facility hours of operations (1)							
11.00	CLINIC	08:00	16:00	08:00	14:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1305	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/24/2022 8:35 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)		0.446269	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		5,687,830	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		16,892,757	6.00	
7.00	Medicaid cost (line 1 times line 6)		7,538,714	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)		1,850,884	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,850,884	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)	138,234	268,835	407,069	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	61,690	268,835	330,525	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,864	11,229	13,093	22.00
23.00	Cost of charity care (line 21 minus line 22)	59,826	257,606	317,432	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,064,599	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		229,693	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		353,373	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		711,226	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		441,078	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		758,510	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,609,394	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1305

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

Worksheet A

Date/Time Prepared:
5/24/2022 8:35 am

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,265,016	1,265,016	-1,219,440	45,576	1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B		0	0	1,538,072	1,538,072	1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB		0	0	356,348	356,348	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		797,643	797,643	33,812	831,455	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP		0	0	11,763	11,763	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	216,160	4,009,376	4,225,536	-36,205	4,189,331	4.00
5.01	00550	ADMINISTRATION & GENERAL	2,234,085	2,877,900	5,111,985	337,581	5,449,566	5.01
7.00	00700	OPERATION OF PLANT	238,844	565,462	804,306	0	804,306	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	105,113	105,113	0	105,113	8.00
9.00	00900	HOUSEKEEPING	205,683	56,816	262,499	0	262,499	9.00
10.00	01000	DIETARY	219,910	142,287	362,197	-174,209	187,988	10.00
11.00	01100	CAFETERIA	0	0	0	174,209	174,209	11.00
13.00	01300	NURSING ADMINISTRATION	164,803	52,617	217,420	-78,946	138,474	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	304,570	4,445	309,015	0	309,015	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	78,946	78,946	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	397,540	373,717	771,257	0	771,257	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,166,106	579,984	1,746,090	466,427	2,212,517	30.00
43.00	04300	NURSERY	0	0	0	417,454	417,454	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	575,147	1,285,123	1,860,270	819	1,861,089	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	329,063	603,846	932,909	-815,570	117,339	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	786,757	456,273	1,243,030	0	1,243,030	54.00
56.00	05600	RADIOISOTOPE	0	206,275	206,275	0	206,275	56.00
60.00	06000	LABORATORY	826,738	1,406,440	2,233,178	0	2,233,178	60.00
60.02	06002	GEO PSYCH	92,883	63,176	156,059	0	156,059	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	80,556	80,556	0	80,556	62.00
65.00	06500	RESPIRATORY THERAPY	301,873	76,993	378,866	-65,529	313,337	65.00
66.00	06600	PHYSICAL THERAPY	119,667	61,241	180,908	0	180,908	66.00
69.00	06900	ELECTROCARDIOLOGY	0	14,793	14,793	65,529	80,322	69.00
69.01	06901	PULMONARY REHAB	50,168	738	50,906	0	50,906	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	36,465	36,465	0	36,465	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	404,705	404,705	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	227,853	1,387,771	1,615,624	176,563	1,792,187	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5,945,525	1,298,395	7,243,920	-846,333	6,397,587	88.00
90.00	09000	CLINIC	319,878	1,216,212	1,536,090	-337,456	1,198,634	90.00
91.00	09100	EMERGENCY	520,504	2,045,116	2,565,620	0	2,565,620	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	159,308	23,124	182,432	0	182,432	93.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		738,014	738,014	-738,014	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,403,065	21,830,927	37,233,992	-249,474	36,984,518	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	641,198	281,963	923,161	249,474	1,172,635	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	12,401	27,423	39,824	0	39,824	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	16,056,664	22,140,313	38,196,977	0	38,196,977	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1305

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

Worksheet A

Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	45,576	1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	-22,801	1,515,271	1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	-23,427	332,921	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	831,455	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	0	11,763	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-65,845	4,123,486	4.00
5.01	00550	ADMINISTRATION & GENERAL	-95,174	5,354,392	5.01
7.00	00700	OPERATION OF PLANT	0	804,306	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	105,113	8.00
9.00	00900	HOUSEKEEPING	0	262,499	9.00
10.00	01000	DIETARY	-623	187,365	10.00
11.00	01100	CAFETERIA	-66,633	107,576	11.00
13.00	01300	NURSING ADMINISTRATION	0	138,474	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,161	301,854	16.00
17.00	01700	SOCIAL SERVICE	0	78,946	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	771,257	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-62,010	2,150,507	30.00
43.00	04300	NURSERY	0	417,454	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-449,437	1,411,652	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	117,339	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,243,030	54.00
56.00	05600	RADIOISOTOPE	0	206,275	56.00
60.00	06000	LABORATORY	0	2,233,178	60.00
60.02	06002	GEO PSYCH	-47,006	109,053	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	80,556	62.00
65.00	06500	RESPIRATORY THERAPY	0	313,337	65.00
66.00	06600	PHYSICAL THERAPY	0	180,908	66.00
69.00	06900	ELECTROCARDIOLOGY	0	80,322	69.00
69.01	06901	PULMONARY REHAB	0	50,906	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	36,465	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	404,705	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-400,181	1,392,006	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-72,339	6,325,248	88.00
90.00	09000	CLINIC	-1,079,426	119,208	90.00
91.00	09100	EMERGENCY	-378,285	2,187,335	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	182,432	93.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,770,348	34,214,170	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,172,635	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	194.00
194.01	07952	FITNESS CENTER	0	39,824	194.01
194.02	07951	BEAUTY SHOP	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,770,348	35,426,629	200.00

RECLASSIFICATIONS

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet A-6
Date/Time Prepared:
5/24/2022 8:35 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS DEPRECIATION EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	955,061		1.00
2.00	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	250,870		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	13,509		3.00
	TOTALS		0	1,219,440		
	B - TO RECLASS CAFETERIA					
1.00	CAFETERIA	11.00	105,772	68,437		1.00
	TOTALS		105,772	68,437		
	C - TO RECLASS RHC DEPR EXPENSE					
1.00	RURAL HEALTH CLINIC	88.00	0	3,950		1.00
	TOTALS		0	3,950		
	D - TO RECLASS SOCIAL SERVICES SALARY					
1.00	SOCIAL SERVICE	17.00	78,946	0		1.00
	TOTALS		78,946	0		
	E - TO RECLASS INTEREST					
1.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	583,011		1.00
2.00	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	105,478		2.00
3.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	49,525		3.00
	TOTALS		0	738,014		
	F - TO RECLASS ACUTE AND NURSERY COSTS					
1.00	ADULTS & PEDIATRICS	30.00	143,490	254,626		1.00
2.00	NURSERY	43.00	150,460	266,994		2.00
	TOTALS		293,950	521,620		
	G - MOB EQUIPMENT DEPRECIATION					
1.00	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	11,763		1.00
	TOTALS		0	11,763		
	H - TO RECLASS EKG TIME					
1.00	ELECTROCARDIOLOGY	69.00	61,594	3,935		1.00
	TOTALS		61,594	3,935		
	I - TO RECLASS NON RHC TIME					
1.00	OPERATING ROOM	50.00	388,314	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	62,010	0		2.00
	TOTALS		450,324	0		
	K - RECLASS ALLOWABLE PHYSICIAN FICA					
1.00	CLINIC	90.00	0	9,599		1.00
2.00	OPERATING ROOM	50.00	0	20,305		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	6,301		3.00
	TOTALS		0	36,205		
	M - IMPLANTABLE SUPPLIES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	404,705		1.00
	TOTALS		0	404,705		
	N - DERMATOLOGY DRUGS RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	176,563		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	176,563		
	O - CARE COORDINATION TIME					
1.00	ADMINISTRATION & GENERAL	5.01	88,766	0		1.00
	TOTALS		88,766	0		
	P - DERMATOLOGY					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	82,743	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	86,735		2.00
	TOTALS		82,743	86,735		
	Q - CARE COORDINATION AND ADMIN TIME					
1.00	ADMINISTRATION & GENERAL	5.01	248,815	0		1.00
	TOTALS		248,815	0		
	R - DR PERLL INSURANCE					
1.00	RURAL HEALTH CLINIC	88.00	0	3,095		1.00
	TOTALS		0	3,095		
	S - INDEPENDENT CLINIC SALARIES					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	237,409	0		1.00
2.00		0.00	0	0		2.00
	TOTALS		237,409	0		
500.00	Grand Total: Increases		1,648,319	3,274,462		500.00

RECLASSIFICATIONS

Provider CCN: 14-1305

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

Worksheet A-6

Date/Time Prepared:
5/24/2022 8:35 am

	Decreases							5/24/2022 8:35 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - TO RECLASS DEPRECIATION EXPENSE							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,219,440	9			1.00
2.00		0.00	0	0	9			2.00
3.00		0.00	0	0	9			3.00
	TOTALS		0	1,219,440				
	B - TO RECLASS CAFETERIA							
1.00	DIETARY	10.00	105,772	68,437	0			1.00
	TOTALS		105,772	68,437				
	C - TO RECLASS RHC DEPR EXPENSE							
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,950	11			1.00
	TOTALS		0	3,950				
	D - TO RECLASS SOCIAL SERVICES SALARY							
1.00	NURSING ADMINISTRATION	13.00	78,946	0	0			1.00
	TOTALS		78,946	0				
	E - TO RECLASS INTEREST							
1.00	INTEREST EXPENSE	113.00	0	738,014	11			1.00
2.00		0.00	0	0	11			2.00
3.00		0.00	0	0	11			3.00
	TOTALS		0	738,014				
	F - TO RECLASS ACUTE AND NURSERY COSTS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	143,490	254,626	0			1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	150,460	266,994	0			2.00
	TOTALS		293,950	521,620				
	G - MOB EQUIPMENT DEPRECIATION							
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	11,763	9			1.00
	TOTALS		0	11,763				
	H - TO RECLASS EKG TIME							
1.00	RESPIRATORY THERAPY	65.00	61,594	3,935	0			1.00
	TOTALS		61,594	3,935				
	I - TO RECLASS NON RHC TIME							
1.00	RURAL HEALTH CLINIC	88.00	450,324	0	0			1.00
2.00		0.00	0	0	0			2.00
	TOTALS		450,324	0				
	K - RECLASS ALLOWABLE PHYSICIAN FICA							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36,205	0			1.00
2.00		0.00	0	0	0			2.00
3.00		0.00	0	0	0			3.00
	TOTALS		0	36,205				
	M - IMPLANTABLE SUPPLIES RECLASS							
1.00	OPERATING ROOM	50.00	0	404,705	0			1.00
	TOTALS		0	404,705				
	N - DERMATOLOGY DRUGS RECLASS							
1.00	CLINIC	90.00	0	107,916	0			1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	68,647	0			2.00
	TOTALS		0	176,563				
	O - CARE COORDINATION TIME							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	88,766	0	0			1.00
	TOTALS		88,766	0				
	P - DERMATOLOGY							
1.00	CLINIC	90.00	82,743	0	0			1.00
2.00	CLINIC	90.00	0	86,735	0			2.00
	TOTALS		82,743	86,735				
	Q - CARE COORDINATION AND ADMIN TIME							
1.00	RURAL HEALTH CLINIC	88.00	248,815	0	0			1.00
	TOTALS		248,815	0				
	R - DR PERLL INSURANCE							
1.00	OPERATING ROOM	50.00	0	3,095	0			1.00
	TOTALS		0	3,095				
	S - INDEPENDENT CLINIC SALARIES							
1.00	CLINIC	90.00	69,661	0	0			1.00
2.00	RURAL HEALTH CLINIC	88.00	167,748	0	0			2.00
	TOTALS		237,409	0				
500.00	Grand Total: Decreases		1,648,319	3,274,462				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part I
Date/Time Prepared:
5/24/2022 8:35 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	499,957	15,000	0	15,000	0	1.00	
2.00	Land Improvements	1,397,947	5,000	0	5,000	0	2.00	
3.00	Buildings and Fixtures	25,234,525	1,739,311	0	1,739,311	76,588	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	8,469,648	1,445,048	0	1,445,048	586,152	6.00	
7.00	HIT designated Assets	1,968,769	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	37,570,846	3,204,359	0	3,204,359	662,740	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	37,570,846	3,204,359	0	3,204,359	662,740	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	514,957	0				1.00	
2.00	Land Improvements	1,402,947	0				2.00	
3.00	Buildings and Fixtures	26,897,248	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	9,328,544	0				6.00	
7.00	HIT designated Assets	1,968,769	0				7.00	
8.00	Subtotal (sum of lines 1-7)	40,112,465	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	40,112,465	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part II
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,265,016	0	0	0	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	0	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	797,643	0	0	0	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,062,659	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,265,016				1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0				1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0				1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	797,643				2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0				2.01
3.00	Total (sum of lines 1-2)	0	2,062,659				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part III
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,809,283	0	1,809,283	0.045105	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	21,578,022	0	21,578,022	0.537938	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	5,427,847	0	5,427,847	0.135316	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	10,796,583	0	10,796,583	0.269158	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	500,730	0	500,730	0.012483	0	2.01
3.00	Total (sum of lines 1-2)	40,112,465	0	40,112,465	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	45,576	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	0	941,658	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	0	250,870	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	785,880	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	11,763	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	2,035,747	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	45,576	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	573,613	0	0	0	1,515,271	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	82,051	0	0	0	332,921	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	45,575	0	0	0	831,455	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	0	11,763	2.01
3.00	Total (sum of lines 1-2)	701,239	0	0	0	2,736,986	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1305

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

Worksheet A-8

Date/Time Prepared:
5/24/2022 8:35 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.02	Investment income - NEW CAP REL COSTS-BLDG & FIXT (NEW B (chapter 2)			0NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1.02
1.03	Investment income - CAP REL COSTS-BLDG & FIXT MOB (chapter 2)			0CAP REL COSTS-BLDG & FIXT MOB	1.03	0	1.03
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - CAP REL COSTS-MOB MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	2.01
3.00	Investment income - other (chapter 2)	B	-13,403	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	9	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,763	ADMINISTRATION & GENERAL	5.01	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	-2,082,009			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	839,509			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-66,633	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-7,161	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-623	DIETARY	10.00	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	0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.02	Depreciation - NEW CAP REL COSTS-BLDG & FIXT (NEW B			0NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	26.02
26.03	Depreciation - CAP REL COSTS-BLDG & FIXT MOB			0CAP REL COSTS-BLDG & FIXT MOB	1.03	0	26.03

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1305

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

Worksheet A-8

Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MOB MVBLE EQUIP			0 CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	27.01
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 *** Cost Center Deleted ***	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 *** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A		0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)			0	0.00	0	33.00
35.00	IT MISC REVENUE	B		0 ADMINISTRATION & GENERAL	5.01	0	35.00
36.00	LOBBYING	A	-8,210	ADMINISTRATION & GENERAL	5.01	0	36.00
39.00	ADVERTISING - HOSPITAL	A	-114,661	ADMINISTRATION & GENERAL	5.01	0	39.00
40.00	ADVERTISING- RHC	A	-28,007	RURAL HEALTH CLINIC	88.00	0	40.00
43.00	PROFESSIONAL LIABILITY	A	-24,137	RURAL HEALTH CLINIC	88.00	0	43.00
44.00	UNNECESSARY BORROWING -HOSPITAL	A	-9,398	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	11	44.00
45.00	CLINIC SALARY REIMBURSEMENT	B	-20,195	RURAL HEALTH CLINIC	88.00	0	45.00
45.03	PROVIDER TAX	A	-676,339	ADMINISTRATION & GENERAL	5.01	0	45.03
45.04	MISC INCOME	B	-80	ADMINISTRATION & GENERAL	5.01	0	45.04
45.05	UNNECESSARY BORROWING - MOB	A	-23,427	CAP REL COSTS-BLDG & FIXT MOB	1.03	11	45.05
45.06	PHYSICIAN RECRUITMENT	A	-115	ADMINISTRATION & GENERAL	5.01	0	45.06
45.08	PURCHASE DISCOUNTS	B	-28,197	ADMINISTRATION & GENERAL	5.01	0	45.08
45.10	MARKETING SALARIES	A	-84,201	ADMINISTRATION & GENERAL	5.01	0	45.10
45.11	MARKETING FRINGES	A	-21,117	ADMINISTRATION & GENERAL	5.01	0	45.11
45.14	340B PHARMACY	A	-400,181	DRUGS CHARGED TO PATIENTS	73.00	0	45.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,770,348				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: 14-1305

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

Worksheet A-8-1

Date/Time Prepared:
5/24/2022 8:35 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	5.01	ADMINISTRATION & GENERAL	MANAGEMENT FEES	0	12,600	1.00
2.00	5.01	ADMINISTRATION & GENERAL	PURCHASED SERVICES	0	307,231	2.00
3.00	5.01	ADMINISTRATION & GENERAL	HOME OFFICE ALLOCATION	1,159,340	0	3.00
4.00	0.00			0	0	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,159,340	319,831	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	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	UNITYPOINT HEAL	100.00	UNITYPOINT HEAL	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: 14-1305

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

Worksheet A-8-1

Date/Time Prepared:
5/24/2022 8:35 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	-12,600	0		1.00
2.00	-307,231	0		2.00
3.00	1,159,340	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
5.00	839,509			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	HEALTH SYSTEM		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: 14-1305

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

Worksheet A-8-2

Date/Time Prepared:
5/24/2022 8:35 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	60.00	LABORATORY	30,833	0	30,833	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	62,010	62,010	0	0	0	2.00
3.00	60.02	GEO PSYCH	47,006	47,006	0	0	0	3.00
4.00	50.00	OPERATING ROOM	449,437	449,437	0	0	0	4.00
5.00	90.00	CLINIC	1,079,426	1,079,426	0	0	0	5.00
6.00	91.00	EMERGENCY	1,953,638	378,285	1,575,353	0	0	6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	65,845	65,845	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			3,688,195	2,082,009	1,606,186		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	60.02	GEO PSYCH	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	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	60.00	LABORATORY	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	62,010		2.00
3.00	60.02	GEO PSYCH	0	0	0	47,006		3.00
4.00	50.00	OPERATING ROOM	0	0	0	449,437		4.00
5.00	90.00	CLINIC	0	0	0	1,079,426		5.00
6.00	91.00	EMERGENCY	0	0	0	378,285		6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	65,845		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	2,082,009		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1305		Period: From 01/01/2021 To 12/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/24/2022 8:35 am		
				Physical Therapy		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						0	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						5.60	7.00
8.00	Optional travel expense rate per mile						0.56	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	116.00	311.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	88.16	66.12	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)	44.08	44.08	33.06			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)						10,227	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						20,563	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						30,790	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)						30,790	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)						72.11	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						56,246	22.00
23.00	Total salary equivalency (see instructions)						56,246	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)						0	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)						0	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)						0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						0	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)						0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1305		Period: From 01/01/2021 To 12/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/24/2022 8:35 am		
				Physical Therapy		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	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)	88.16	66.12	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)						56,246	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	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)						56,246	63.00
64.00	Total cost of outside supplier services (from your records)						36,360	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						0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0	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						0	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						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1305		Period: From 01/01/2021 To 12/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/24/2022 8:35 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	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					5.60	7.00
8.00	Optional travel expense rate per mile					0.56	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	69.00	153.75	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	83.55	62.66	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)	41.78	41.78	31.33			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)					5,765	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					9,634	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					15,399	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)					15,399	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)					69.13	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					53,921	22.00
23.00	Total salary equivalency (see instructions)					53,921	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)					0	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)					0	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)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	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)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	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: 14-1305		Period: From 01/01/2021 To 12/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/24/2022 8:35 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)	83.55	62.66	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)					53,921	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	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)					53,921	63.00
64.00	Total cost of outside supplier services (from your records)					19,299	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					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	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					0	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					0	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1305		Period: From 01/01/2021 To 12/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/24/2022 8:35 am		
				Speech Pathology		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						0	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						5.60	7.00
8.00	Optional travel expense rate per mile						0.56	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	42.25	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	80.28	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)	40.14	40.14	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)						3,392	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)						3,392	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)						3,392	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)						80.28	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						62,618	22.00
23.00	Total salary equivalency (see instructions)						62,618	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)						0	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)						0	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)						0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						0	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)						0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet A-8-3
Parts I-VI
Date/Time Prepared:
5/24/2022 8:35 am

					Speech Pathology	Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	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)	80.28	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)					62,618	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	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)					62,618	63.00
64.00	Total cost of outside supplier services (from your records)					4,063	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					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	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					0	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					0	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: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description			CAPITAL RELATED COSTS					
			Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW BLDG & FIXT (NEW B	BLDG & FIXT MOB		NEW MVBLE EQUIP
			0	1.00	1.02	1.03	2.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	45,576	45,576				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1,515,271	0	1,515,271			1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	332,921	0	0	332,921		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	831,455				831,455	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	11,763				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,123,486	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	5,354,392	16,041	415,802	112,793	238,332	5.01
7.00	00700	OPERATION OF PLANT	804,306	1,993	71,717	0	38,881	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	0	6,805	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	105,113	0	6,210	0	2,870	8.00
9.00	00900	HOUSEKEEPING	262,499		15,558	2,677	7,190	9.00
10.00	01000	DIETARY	187,365	0	29,410	0	13,591	10.00
11.00	01100	CAFETERIA	107,576	0	16,752	0	7,742	11.00
13.00	01300	NURSING ADMINISTRATION	138,474	0	9,041	0	4,178	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	301,854	4,912	26,851	0	26,552	16.00
17.00	01700	SOCIAL SERVICE	78,946	0	5,971	0	2,759	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	771,257	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,150,507	0	333,747	0	154,232	30.00
43.00	04300	NURSERY	417,454	0	7,677	0	3,548	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,411,652	0	136,713	0	63,178	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	117,339	0	30,229	0	13,970	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,243,030	0	151,111	0	69,832	54.00
56.00	05600	RADIOISOTOPE	206,275	0	10,577	0	4,888	56.00
60.00	06000	LABORATORY	2,233,178	0	57,592		26,615	60.00
60.02	06002	GEO PSYCH	109,053	0	0	12,944	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	80,556	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	313,337	0	23,576	0	10,895	65.00
66.00	06600	PHYSICAL THERAPY	180,908	0	8,837	0	4,084	66.00
69.00	06900	ELECTROCARDIOLOGY	80,322	0	38,383	0	17,738	69.00
69.01	06901	PULMONARY REHAB	50,906	0	0	12,797	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,465	0	11,123	0	5,140	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	404,705	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,392,006	0	42,682	0	19,724	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,325,248	22,630	0	112,101	65,149	88.00
90.00	09000	CLINIC	119,208	0	0	10,281	0	90.00
91.00	09100	EMERGENCY	2,187,335	0	63,187	0	29,200	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	182,432	0	0	8,736	0	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,214,170	45,576	1,512,746	279,134	830,288	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,525	0	1,167	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,172,635	0	0	53,787	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	39,824	0	0	0	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	35,426,629	45,576	1,515,271	332,921	831,455	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description			CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATION & GENERAL	OPERATION OF PLANT	
			MOB MVBLE EQUIP					
			2.01	4.00	4A	5.01	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	11,763					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,123,486				4.00
5.01	00550	ADMINISTRATION & GENERAL	3,986	692,174	6,833,520	6,833,520		5.01
7.00	00700	OPERATION OF PLANT	0	64,286	981,183	234,495	1,215,678	7.00
7.01	00701	OPERATION OF PLANT MOB	240	0	7,045	1,684	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	114,193	27,291	7,345	8.00
9.00	00900	HOUSEKEEPING	95	55,360	343,379	82,065	18,403	9.00
10.00	01000	DIETARY	0	30,721	261,087	62,398	34,788	10.00
11.00	01100	CAFETERIA	0	28,469	160,539	38,368	19,815	11.00
13.00	01300	NURSING ADMINISTRATION	0	23,109	174,802	41,776	10,695	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	81,976	442,145	105,669	31,761	16.00
17.00	01700	SOCIAL SERVICE	0	21,249	108,925	26,032	7,062	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	106,999	878,256	209,896	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	352,483	2,990,969	714,818	394,775	30.00
43.00	04300	NURSEY	0	40,497	469,176	112,129	9,080	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	154,803	1,766,346	422,143	161,711	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,451	170,989	40,865	35,756	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	211,759	1,675,732	400,487	178,742	54.00
56.00	05600	RADIOISOTOPE	0	0	221,740	52,994	12,511	56.00
60.00	06000	LABORATORY	0	222,520	2,539,905	607,017	68,123	60.00
60.02	06002	GEO PSYCH	457	25,000	147,454	35,240	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	80,556	19,252	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	64,672	412,480	98,579	27,887	65.00
66.00	06600	PHYSICAL THERAPY	0	32,209	226,038	54,021	10,452	66.00
69.00	06900	ELECTROCARDIOLOGY	0	16,578	153,021	36,571	45,402	69.00
69.01	06901	PULMONARY REHAB	452	13,503	77,658	18,560	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	52,728	12,602	13,156	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	404,705	96,721	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	61,328	1,515,740	362,250	50,487	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,961	1,366,929	7,896,018	1,887,080	0	88.00
90.00	09000	CLINIC	363	26,240	156,092	37,305	0	90.00
91.00	09100	EMERGENCY	0	140,096	2,419,818	578,317	74,741	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	309	42,878	234,355	56,009	0	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,863	3,885,289	33,916,594	6,472,634	1,212,692	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,692	882	2,986	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,900	234,859	1,463,181	349,689	0	192.00
194.00	07950	NAUV00 APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	3,338	43,162	10,315	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments			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)	11,763	4,123,486	35,426,629	6,833,520	1,215,678	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description			OPERATION OF PLANT MOB	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB	8,729					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	148,829				8.00
9.00	00900	HOUSEKEEPING	110	0	443,957			9.00
10.00	01000	DIETARY	0	0	7,603	365,876		10.00
11.00	01100	CAFETERIA	0	0	4,331	0	223,053	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,337	0	6,113	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	14,854	0	14,314	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,544	0	3,574	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	1,392	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	48,198	86,283	365,876	38,824	30.00
43.00	04300	NURSERY	0	0	1,985	0	4,413	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	55,772	35,344	0	17,730	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	7,815	0	1,033	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,762	39,066	0	21,763	54.00
56.00	05600	RADIOISOTOPE	0	0	2,734	0	0	56.00
60.00	06000	LABORATORY	0	0	14,889	0	27,782	60.00
60.02	06002	GEO PSYCH	530	0	8,574	0	3,651	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	6,095	0	7,565	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,285	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	9,923	0	1,939	69.00
69.01	06901	PULMONARY REHAB	524	0	8,477	0	1,939	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,876	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	11,035	0	4,706	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,586	8,441	110,697	0	50,399	88.00
90.00	09000	CLINIC	421	0	6,809	0	0	90.00
91.00	09100	EMERGENCY	0	18,656	16,336	0	13,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	357	0	5,786	0	1,932	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,528	148,829	407,678	365,876	223,053	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	653	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,201	0	35,626	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07951	BEAUTY SHOP	0	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)	8,729	148,829	443,957	365,876	223,053	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description			NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
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	235,723					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	608,743				16.00
17.00	01700	SOCIAL SERVICE	0	0	147,137			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	3,509	0	0	1,093,053		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	97,861	42,594	144,194	0	4,924,392	30.00
43.00	04300	NURSERY	11,123	1,393	0	0	609,299	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	44,691	68,682	0	0	2,572,419	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,603	2,372	0	0	261,433	52.00
53.00	05300	ANESTHESIOLOGY	0	26,427	0	1,093,053	1,119,480	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	120,964	0	0	2,454,516	54.00
56.00	05600	RADIOISOTOPE	0	5,262	0	0	295,241	56.00
60.00	06000	LABORATORY	0	132,974	0	0	3,390,690	60.00
60.02	06002	GEO PSYCH	0	2,297	0	0	197,746	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	835	0	0	100,643	62.00
65.00	06500	RESPIRATORY THERAPY	19,069	14,426	0	0	586,101	65.00
66.00	06600	PHYSICAL THERAPY	0	6,746	0	0	299,542	66.00
69.00	06900	ELECTROCARDIOLOGY	4,887	7,344	0	0	259,087	69.00
69.01	06901	PULMONARY REHAB	0	2,391	0	0	109,549	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,892	0	0	88,254	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,717	0	0	509,143	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,861	39,607	0	0	1,995,686	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	79,261	0	0	10,036,482	88.00
90.00	09000	CLINIC	0	2,497	0	0	203,124	90.00
91.00	09100	EMERGENCY	35,249	37,670	2,943	0	3,197,714	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	4,870	392	0	0	303,701	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	235,723	608,743	147,137	1,093,053	33,514,242	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	8,213	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,850,697	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	0	53,477	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	235,723	608,743	147,137	1,093,053	35,426,629	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B			1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB			1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	ADMINISTRATION & GENERAL			5.01
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT MOB			7.01
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
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	0	4,924,392	30.00
43.00	04300	NURSERY	0	609,299	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,572,419	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	261,433	52.00
53.00	05300	ANESTHESIOLOGY	0	1,119,480	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,454,516	54.00
56.00	05600	RADIOISOTOPE	0	295,241	56.00
60.00	06000	LABORATORY	0	3,390,690	60.00
60.02	06002	GEO PSYCH	0	197,746	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	100,643	62.00
65.00	06500	RESPIRATORY THERAPY	0	586,101	65.00
66.00	06600	PHYSICAL THERAPY	0	299,542	66.00
69.00	06900	ELECTROCARDIOLOGY	0	259,087	69.00
69.01	06901	PULMONARY REHAB	0	109,549	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	88,254	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	509,143	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,995,686	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	10,036,482	88.00
90.00	09000	CLINIC	0	203,124	90.00
91.00	09100	EMERGENCY	0	3,197,714	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	303,701	93.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	33,514,242	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,213	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,850,697	192.00
194.00	07950	NAUV00 APARTMENTS	0	0	194.00
194.01	07952	FITNESS CENTER	0	53,477	194.01
194.02	07951	BEAUTY SHOP	0	0	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	35,426,629	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			NEW BLDG & FIXT	NEW BLDG & FIXT (NEW B	BLDG & FIXT MOB	NEW MVBLE EQUIP	
		0	1.00	1.02	1.03	2.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B					1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	0	16,041	415,802	112,793	238,332
7.00	00700	OPERATION OF PLANT	0	1,993	71,717	0	38,881
7.01	00701	OPERATION OF PLANT MOB	0	0	0	6,805	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	6,210	0	2,870
9.00	00900	HOUSEKEEPING	0	0	15,558	2,677	7,190
10.00	01000	DIETARY	0	0	29,410	0	13,591
11.00	01100	CAFETERIA	0	0	16,752	0	7,742
13.00	01300	NURSING ADMINISTRATION	0	0	9,041	0	4,178
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,912	26,851	0	26,552
17.00	01700	SOCIAL SERVICE	0	0	5,971	0	2,759
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	333,747	0	154,232
43.00	04300	NURSERY	0	0	7,677	0	3,548
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	136,713	0	63,178
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	30,229	0	13,970
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	151,111	0	69,832
56.00	05600	RADIOISOTOPE	0	0	10,577	0	4,888
60.00	06000	LABORATORY	0	0	57,592	0	26,615
60.02	06002	GEO PSYCH	0	0	0	12,944	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	23,576	0	10,895
66.00	06600	PHYSICAL THERAPY	0	0	8,837	0	4,084
69.00	06900	ELECTROCARDIOLOGY	0	0	38,383	0	17,738
69.01	06901	PULMONARY REHAB	0	0	0	12,797	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	11,123	0	5,140
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	42,682	0	19,724
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	22,630	0	112,101	65,149
90.00	09000	CLINIC	0	0	0	10,281	0
91.00	09100	EMERGENCY	0	0	63,187	0	29,200
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
93.01	04950	DIABETIC EDUCATION	0	0	0	8,736	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	45,576	1,512,746	279,134	830,288
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,525	0	1,167
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	53,787	0
194.00	07950	NAUV00 APARTMENTS	0	0	0	0	0
194.01	07952	FITNESS CENTER	0	0	0	0	0
194.02	07951	BEAUTY SHOP	0	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	0	45,576	1,515,271	332,921	831,455

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description			CAPITAL RELATED COSTS	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATION & GENERAL	OPERATION OF PLANT	
			MOB MVBLE EQUIP					
			2.01	2A	4.00	5.01	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0			4.00
5.01	00550	ADMINISTRATION & GENERAL	3,986	786,954	0	786,954		5.01
7.00	00700	OPERATION OF PLANT	0	112,591	0	27,005	139,596	7.00
7.01	00701	OPERATION OF PLANT MOB	240	7,045	0	194	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,080	0	3,143	843	8.00
9.00	00900	HOUSEKEEPING	95	25,520	0	9,451	2,113	9.00
10.00	01000	DIETARY	0	43,001	0	7,186	3,995	10.00
11.00	01100	CAFETERIA	0	24,494	0	4,419	2,275	11.00
13.00	01300	NURSING ADMINISTRATION	0	13,219	0	4,811	1,228	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	58,315	0	12,169	3,647	16.00
17.00	01700	SOCIAL SERVICE	0	8,730	0	2,998	811	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	24,172	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	487,979	0	82,320	45,332	30.00
43.00	04300	NURSERY	0	11,225	0	12,913	1,043	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	199,891	0	48,615	18,569	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	44,199	0	4,706	4,106	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	220,943	0	46,121	20,525	54.00
56.00	05600	RADIOISOTOPE	0	15,465	0	6,103	1,437	56.00
60.00	06000	LABORATORY	0	84,207	0	69,906	7,823	60.00
60.02	06002	GEO PSYCH	457	13,401	0	4,058	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	2,217	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	34,471	0	11,353	3,202	65.00
66.00	06600	PHYSICAL THERAPY	0	12,921	0	6,221	1,200	66.00
69.00	06900	ELECTROCARDIOLOGY	0	56,121	0	4,212	5,213	69.00
69.01	06901	PULMONARY REHAB	452	13,249	0	2,137	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,263	0	1,451	1,511	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,139	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	62,406	0	41,718	5,797	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,961	203,841	0	217,308	0	88.00
90.00	09000	CLINIC	363	10,644	0	4,296	0	90.00
91.00	09100	EMERGENCY	0	92,387	0	66,601	8,583	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	309	9,045	0	6,450	0	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,863	2,677,607	0	745,393	139,253	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,692	0	102	343	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,900	55,687	0	40,271	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	1,188	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,763	2,736,986	0	786,954	139,596	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description			OPERATION OF PLANT MOB	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB	7,239					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,066				8.00
9.00	00900	HOUSEKEEPING	91	0	37,175			9.00
10.00	01000	DIETARY	0	0	637	54,819		10.00
11.00	01100	CAFETERIA	0	0	363	0	31,551	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	196	0	865	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,244	0	2,025	16.00
17.00	01700	SOCIAL SERVICE	0	0	129	0	505	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	197	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	4,231	7,225	54,819	5,492	30.00
43.00	04300	NURSERY	0	0	166	0	624	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,897	2,960	0	2,508	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	654	0	146	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,559	3,271	0	3,078	54.00
56.00	05600	RADIOISOTOPE	0	0	229	0	0	56.00
60.00	06000	LABORATORY	0	0	1,247	0	3,930	60.00
60.02	06002	GEO PSYCH	439	0	718	0	516	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	510	0	1,070	65.00
66.00	06600	PHYSICAL THERAPY	0	0	191	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	831	0	274	69.00
69.01	06901	PULMONARY REHAB	434	0	710	0	274	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	241	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	924	0	666	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,805	741	9,268	0	7,130	88.00
90.00	09000	CLINIC	349	0	570	0	0	90.00
91.00	09100	EMERGENCY	0	1,638	1,368	0	1,978	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	296	0	485	0	273	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,414	13,066	34,137	54,819	31,551	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	55	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,825	0	2,983	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07951	BEAUTY SHOP	0	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)	7,239	13,066	37,175	54,819	31,551	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
		13.00	16.00	17.00	19.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B					1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	ADMINISTRATION & GENERAL					5.01
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT MOB					7.01
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	20,319				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	77,400			16.00
17.00	01700	SOCIAL SERVICE	0	0	13,173		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	302	0	0	24,671	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,437	5,417	12,910	714,162	30.00
43.00	04300	NURSERY	959	177	0	27,107	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,852	8,736	0	290,028	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	224	302	0	54,337	52.00
53.00	05300	ANESTHESIOLOGY	0	3,361	0	3,361	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,385	0	310,882	54.00
56.00	05600	RADIOISOTOPE	0	669	0	23,903	56.00
60.00	06000	LABORATORY	0	16,887	0	184,000	60.00
60.02	06002	GEO PSYCH	0	292	0	19,424	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	106	0	2,323	62.00
65.00	06500	RESPIRATORY THERAPY	1,644	1,835	0	54,085	65.00
66.00	06600	PHYSICAL THERAPY	0	858	0	21,391	66.00
69.00	06900	ELECTROCARDIOLOGY	421	934	0	68,006	69.00
69.01	06901	PULMONARY REHAB	0	304	0	17,108	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	877	0	20,343	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	982	0	12,121	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,022	5,038	0	117,571	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	10,081	0	452,174	88.00
90.00	09000	CLINIC	0	318	0	16,177	90.00
91.00	09100	EMERGENCY	3,038	4,791	263	180,647	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	420	50	0	17,019	93.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,319	77,400	13,173	0	2,606,169
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	4,192	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	100,766	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	1,188	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	194.02
200.00		Cross Foot Adjustments				24,671	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	20,319	77,400	13,173	24,671	2,736,986

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B			1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB			1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	ADMINISTRATION & GENERAL			5.01
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT MOB			7.01
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
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	0	714,162	30.00
43.00	04300	NURSERY	0	27,107	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	290,028	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	54,337	52.00
53.00	05300	ANESTHESIOLOGY	0	3,361	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	310,882	54.00
56.00	05600	RADIOISOTOPE	0	23,903	56.00
60.00	06000	LABORATORY	0	184,000	60.00
60.02	06002	GEO PSYCH	0	19,424	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2,323	62.00
65.00	06500	RESPIRATORY THERAPY	0	54,085	65.00
66.00	06600	PHYSICAL THERAPY	0	21,391	66.00
69.00	06900	ELECTROCARDIOLOGY	0	68,006	69.00
69.01	06901	PULMONARY REHAB	0	17,108	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,343	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,121	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	117,571	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	452,174	88.00
90.00	09000	CLINIC	0	16,177	90.00
91.00	09100	EMERGENCY	0	180,647	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	17,019	93.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,606,169	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,192	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	100,766	192.00
194.00	07950	NAUV00 APARTMENTS	0	0	194.00
194.01	07952	FITNESS CENTER	0	1,188	194.01
194.02	07951	BEAUTY SHOP	0	0	194.02
200.00		Cross Foot Adjustments	0	24,671	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,736,986	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1305

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

Worksheet B-1

Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description			CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (WFMG/ADMIN SQUARE FEET)	NEW BLDG & FIXT (NEW B (NEW HOSP SQUARE FE)	BLDG & FIXT MOB (MOB SQUARE FEET)	NEW MVBLE EQUIP (HOSP/WFMG/ADM IN SQUARE FEET)	MOB MVBLE EQUIP (MOB SQUARE FEET)	
			1.00	1.02	1.03	2.00	2.01	
	GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	8,322					1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	44,412				1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	0	0	25,000			1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				52,734		2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				0	25,000	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	2,929	12,187	8,470	15,116	8,470	5.01
7.00	00700	OPERATION OF PLANT	364	2,102	0	2,466	0	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	511	0	511	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	182	0	182	0	8.00
9.00	00900	HOUSEKEEPING	0	456	201	456	201	9.00
10.00	01000	DIETARY	0	862	0	862	0	10.00
11.00	01100	CAFETERIA	0	491	0	491	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	265	0	265	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	897	787	0	1,684	0	16.00
17.00	01700	SOCIAL SERVICE	0	175	0	175	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	9,782	0	9,782	0	30.00
43.00	04300	NURSERY	0	225	0	225	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	4,007	0	4,007	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	886	0	886	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,429	0	4,429	0	54.00
56.00	05600	RADIOISOTOPE	0	310	0	310	0	56.00
60.00	06000	LABORATORY	0	1,688	0	1,688	0	60.00
60.02	06002	GEO PSYCH	0	0	972	0	972	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	691	0	691	0	65.00
66.00	06600	PHYSICAL THERAPY	0	259	0	259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,125	0	1,125	0	69.00
69.01	06901	PULMONARY REHAB	0	0	961	0	961	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	326	0	326	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	1,251	0	1,251	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,132	0	8,418	4,132	8,418	88.00
90.00	09000	CLINIC	0	0	772	0	772	90.00
91.00	09100	EMERGENCY	0	1,852	0	1,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	656	0	656	93.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,322	44,338	20,961	52,660	20,961	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74	0	74	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,039	0	4,039	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07951	BEAUTY SHOP	0	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)	45,576	1,515,271	332,921	831,455	11,763	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.476568	34.118504	13.316840	15.766962	0.470520	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1305

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

Worksheet B-1

Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT (SALARIES)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	OPERATION OF PLANT (HOSP ONLY SQUARE FT)	OPERATION OF PLANT MOB (MOB SQUARE FEET)	
			4.00	5A.01	5.01	7.00	7.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	15,320,196					4.00
5.01	00550	ADMINISTRATION & GENERAL	2,571,666	-6,833,520	28,593,109			5.01
7.00	00700	OPERATION OF PLANT	238,844	0	981,183	30,123		7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	7,045	0	16,019	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	114,193	182	0	8.00
9.00	00900	HOUSEKEEPING	205,683	0	343,379	456	201	9.00
10.00	01000	DIETARY	114,138	0	261,087	862	0	10.00
11.00	01100	CAFETERIA	105,772	0	160,539	491	0	11.00
13.00	01300	NURSING ADMINISTRATION	85,857	0	174,802	265	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	304,570	0	442,145	787	0	16.00
17.00	01700	SOCIAL SERVICE	78,946	0	108,925	175	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	397,540	0	878,256	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,309,596	0	2,990,969	9,782	0	30.00
43.00	04300	NURSERY	150,460	0	469,176	225	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	575,147	0	1,766,346	4,007	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	35,113	0	170,989	886	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	786,757	0	1,675,732	4,429	0	54.00
56.00	05600	RADIOISOTOPE	0	0	221,740	310	0	56.00
60.00	06000	LABORATORY	826,738	0	2,539,905	1,688	0	60.00
60.02	06002	GEO PSYCH	92,883	0	147,454	0	972	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	80,556	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	240,279	0	412,480	691	0	65.00
66.00	06600	PHYSICAL THERAPY	119,667	0	226,038	259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	61,594	0	153,021	1,125	0	69.00
69.01	06901	PULMONARY REHAB	50,168	0	77,658	0	961	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	52,728	326	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	404,705	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	227,853	0	1,515,740	1,251	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,078,638	0	7,896,018	0	8,418	88.00
90.00	09000	CLINIC	97,490	0	156,092	0	772	90.00
91.00	09100	EMERGENCY	520,504	0	2,419,818	1,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	159,308	0	234,355	0	656	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,435,211	-6,833,520	27,083,074	30,049	11,980	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,692	74	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	872,584	0	1,463,181	0	4,039	192.00
194.00	07950	NAUV00 APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	12,401	0	43,162	0	0	194.01
194.02	07951	BEAUTY SHOP	0	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)	4,123,486		6,833,520	1,215,678	8,729	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.269154		0.238992	40.357136	0.544915	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		786,954	139,596	7,239	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.027523	4.634200	0.451901	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: 14-1305

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

Worksheet B-1

Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (NEW HOSP, WFMG/ADMIN, MOB SQFT)	DIETARY (HOSP PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	54,766					8.00
9.00	00900	HOUSEKEEPING	0	50,332				9.00
10.00	01000	DIETARY	0	862	2,564			10.00
11.00	01100	CAFETERIA	0	491	0	240,802		11.00
13.00	01300	NURSING ADMINISTRATION	0	265	0	6,599	100,959	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,684	0	15,453	0	16.00
17.00	01700	SOCIAL SERVICE	0	175	0	3,858	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1,503	1,503	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,736	9,782	2,564	41,913	41,913	30.00
43.00	04300	NURSERY	0	225	0	4,764	4,764	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,523	4,007	0	19,141	19,141	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	886	0	1,115	1,115	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,536	4,429	0	23,495	0	54.00
56.00	05600	RADIOISOTOPE	0	310	0	0	0	56.00
60.00	06000	LABORATORY	0	1,688	0	29,993	0	60.00
60.02	06002	GEO PSYCH	0	972	0	3,941	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	691	0	8,167	8,167	65.00
66.00	06600	PHYSICAL THERAPY	0	259	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,125	0	2,093	2,093	69.00
69.01	06901	PULMONARY REHAB	0	961	0	2,093	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	326	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	1,251	0	5,080	5,080	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,106	12,550	0	54,411	0	88.00
90.00	09000	CLINIC	0	772	0	0	0	90.00
91.00	09100	EMERGENCY	6,865	1,852	0	15,097	15,097	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	656	0	2,086	2,086	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,766	46,219	2,564	240,802	100,959	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,039	0	0	0	192.00
194.00	07950	NAUV00 APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07951	BEAUTY SHOP	0	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)	148,829	443,957	365,876	223,053	235,723	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.717544	8.820571	142.697348	0.926292	2.334839	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	13,066	37,175	54,819	31,551	20,319	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.238579	0.738596	21.380265	0.131025	0.201260	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: 14-1305

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

Worksheet B-1

Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B				1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB				1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	ADMINISTRATION & GENERAL				5.01
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT MOB				7.01
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
16.00	01600	MEDICAL RECORDS & LIBRARY	75,098,769			16.00
17.00	01700	SOCIAL SERVICE	0	100		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	2,080	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,254,573	98	0	30.00
43.00	04300	NURSERY	171,840	0	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,472,950	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	292,661	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,260,207	0	2,080	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,922,722	0	0	54.00
56.00	05600	RADIOISOTOPE	649,145	0	0	56.00
60.00	06000	LABORATORY	16,405,238	0	0	60.00
60.02	06002	GEO PSYCH	283,426	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	103,066	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,779,685	0	0	65.00
66.00	06600	PHYSICAL THERAPY	832,186	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	905,959	0	0	69.00
69.01	06901	PULMONARY REHAB	294,994	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	850,276	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	952,025	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,886,150	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,778,009	0	0	88.00
90.00	09000	CLINIC	308,027	0	0	90.00
91.00	09100	EMERGENCY	4,647,218	2	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	48,412	0	0	93.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,098,769	100	2,080	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	NAUV00 APARTMENTS	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	194.01
194.02	07951	BEAUTY SHOP	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)	608,743	147,137	1,093,053	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.008106	1,471.370000	525.506250	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	77,400	13,173	24,671	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001031	131.730000	11.861058	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/24/2022 8:35 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	4,924,392		4,924,392	0	0	30.00
43.00	04300	NURSERY	609,299		609,299	0	0	43.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,572,419		2,572,419	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	261,433		261,433	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,119,480		1,119,480	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,454,516		2,454,516	0	0	54.00
56.00	05600	RADIOISOTOPE	295,241		295,241	0	0	56.00
60.00	06000	LABORATORY	3,390,690		3,390,690	0	0	60.00
60.02	06002	GEO PSYCH	197,746		197,746	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	100,643		100,643	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	586,101	0	586,101	0	0	65.00
66.00	06600	PHYSICAL THERAPY	299,542	0	299,542	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	259,087		259,087	0	0	69.00
69.01	06901	PULMONARY REHAB	109,549		109,549	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	88,254		88,254	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	509,143		509,143	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,995,686		1,995,686	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	10,036,482		10,036,482	0	0	88.00
90.00	09000	CLINIC	203,124		203,124	0	0	90.00
91.00	09100	EMERGENCY	3,197,714		3,197,714	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	446,580		446,580	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	303,701		303,701	0	0	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	33,960,822	0	33,960,822	0	0	200.00
201.00		Less Observation Beds	446,580		446,580			201.00
202.00		Total (see instructions)	33,514,242	0	33,514,242	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/24/2022 8:35 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	3,983,703		3,983,703		
43.00	04300	NURSERY	171,840		171,840		
46.00	04600	OTHER LONG TERM CARE	0		0		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,330,239	7,142,711	8,472,950	0.303604	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	202,477	90,184	292,661	0.893296	0.000000
53.00	05300	ANESTHESIOLOGY	162,070	3,098,137	3,260,207	0.343377	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	773,526	14,149,196	14,922,722	0.164482	0.000000
56.00	05600	RADIOISOTOPE	13,380	635,765	649,145	0.454815	0.000000
60.00	06000	LABORATORY	1,595,968	14,809,270	16,405,238	0.206683	0.000000
60.02	06002	GEO PSYCH	0	283,426	283,426	0.697699	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	31,610	71,456	103,066	0.976491	0.000000
65.00	06500	RESPIRATORY THERAPY	984,403	795,282	1,779,685	0.329329	0.000000
66.00	06600	PHYSICAL THERAPY	685,301	146,885	832,186	0.359946	0.000000
69.00	06900	ELECTROCARDIOLOGY	41,616	864,343	905,959	0.285981	0.000000
69.01	06901	PULMONARY REHAB	0	294,994	294,994	0.371360	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	523,193	327,083	850,276	0.103795	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	250,000	702,025	952,025	0.534800	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	2,090,413	2,795,737	4,886,150	0.408437	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	9,778,009	9,778,009		
90.00	09000	CLINIC	63	307,964	308,027	0.659436	0.000000
91.00	09100	EMERGENCY	151,488	4,495,730	4,647,218	0.688092	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	75,756	1,195,114	1,270,870	0.351397	0.000000
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000
93.01	04950	DIABETIC EDUCATION	0	48,412	48,412	6.273259	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	13,067,046	62,031,723	75,098,769		
201.00		Less Observation Beds					
202.00		Total (see instructions)	13,067,046	62,031,723	75,098,769		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/24/2022 8:35 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
43.00	04300	NURSERY				43.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
60.00	06000	LABORATORY	0.000000			60.00
60.02	06002	GEO PSYCH	0.000000			60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
69.01	06901	PULMONARY REHAB	0.000000			69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000			93.00
93.01	04950	DIABETIC EDUCATION	0.000000			93.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

Worksheet C
Part I
Date/Time Prepared:
5/24/2022 8:35 am

MCRIF32 - 17.4.174.1

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/24/2022 8:35 am

			Title XIX		Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,983,703		3,983,703			30.00
43.00	04300	NURSERY	171,840		171,840			43.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,330,239	7,142,711	8,472,950	0.303604	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	202,477	90,184	292,661	0.893296	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	162,070	3,098,137	3,260,207	0.343377	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	773,526	14,149,196	14,922,722	0.164482	0.000000	54.00
56.00	05600	RADIOISOTOPE	13,380	635,765	649,145	0.454815	0.000000	56.00
60.00	06000	LABORATORY	1,595,968	14,809,270	16,405,238	0.206683	0.000000	60.00
60.02	06002	GEO PSYCH	0	283,426	283,426	0.697699	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	31,610	71,456	103,066	0.976491	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	984,403	795,282	1,779,685	0.329329	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	685,301	146,885	832,186	0.359946	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	41,616	864,343	905,959	0.285981	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	294,994	294,994	0.371360	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	523,193	327,083	850,276	0.103795	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	250,000	702,025	952,025	0.534800	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,090,413	2,795,737	4,886,150	0.408437	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	9,778,009	9,778,009	1.026434	0.000000	88.00
90.00	09000	CLINIC	63	307,964	308,027	0.659436	0.000000	90.00
91.00	09100	EMERGENCY	151,488	4,495,730	4,647,218	0.688092	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	75,756	1,195,114	1,270,870	0.351397	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	48,412	48,412	6.273259	0.000000	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	13,067,046	62,031,723	75,098,769			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,067,046	62,031,723	75,098,769			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
46.00	04600	OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.303604		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.893296		52.00
53.00	05300	ANESTHESIOLOGY	0.343377		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164482		54.00
56.00	05600	RADIOISOTOPE	0.454815		56.00
60.00	06000	LABORATORY	0.206683		60.00
60.02	06002	GEO PSYCH	0.697699		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.976491		62.00
65.00	06500	RESPIRATORY THERAPY	0.329329		65.00
66.00	06600	PHYSICAL THERAPY	0.359946		66.00
69.00	06900	ELECTROCARDIOLOGY	0.285981		69.00
69.01	06901	PULMONARY REHAB	0.371360		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.103795		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.534800		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.408437		73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1.026434		88.00
90.00	09000	CLINIC	0.659436		90.00
91.00	09100	EMERGENCY	0.688092		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.351397		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
93.01	04950	DIABETIC EDUCATION	6.273259		93.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part II
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description		Title XIX			Hospital	PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,572,419	290,028	2,282,391	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	261,433	54,337	207,096	0	52.00
53.00	05300	ANESTHESIOLOGY	1,119,480	3,361	1,116,119	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,454,516	310,882	2,143,634	0	54.00
56.00	05600	RADIOISOTOPE	295,241	23,903	271,338	0	56.00
60.00	06000	LABORATORY	3,390,690	184,000	3,206,690	0	60.00
60.02	06002	GEO PSYCH	197,746	19,424	178,322	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	100,643	2,323	98,320	0	62.00
65.00	06500	RESPIRATORY THERAPY	586,101	54,085	532,016	0	65.00
66.00	06600	PHYSICAL THERAPY	299,542	21,391	278,151	0	66.00
69.00	06900	ELECTROCARDIOLOGY	259,087	68,006	191,081	0	69.00
69.01	06901	PULMONARY REHAB	109,549	17,108	92,441	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	88,254	20,343	67,911	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	509,143	12,121	497,022	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,995,686	117,571	1,878,115	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	10,036,482	452,174	9,584,308	0	88.00
90.00	09000	CLINIC	203,124	16,177	186,947	0	90.00
91.00	09100	EMERGENCY	3,197,714	180,647	3,017,067	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	446,580	64,765	381,815	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	303,701	17,019	286,682	0	93.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	28,427,131	1,929,665	26,497,466	0	200.00
201.00		Less Observation Beds	446,580	64,765	381,815	0	201.00
202.00		Total (line 200 minus line 201)	27,980,551	1,864,900	26,115,651	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part II
Date/Time Prepared:
5/24/2022 8:35 am

			Title XIX		Hospital	PPS
	Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
		6.00	7.00	8.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,572,419	8,472,950	0.303604	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	261,433	292,661	0.893296	52.00
53.00	05300	ANESTHESIOLOGY	1,119,480	3,260,207	0.343377	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,454,516	14,922,722	0.164482	54.00
56.00	05600	RADIOISOTOPE	295,241	649,145	0.454815	56.00
60.00	06000	LABORATORY	3,390,690	16,405,238	0.206683	60.00
60.02	06002	GEO PSYCH	197,746	283,426	0.697699	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	100,643	103,066	0.976491	62.00
65.00	06500	RESPIRATORY THERAPY	586,101	1,779,685	0.329329	65.00
66.00	06600	PHYSICAL THERAPY	299,542	832,186	0.359946	66.00
69.00	06900	ELECTROCARDIOLOGY	259,087	905,959	0.285981	69.00
69.01	06901	PULMONARY REHAB	109,549	294,994	0.371360	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	88,254	850,276	0.103795	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	509,143	952,025	0.534800	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,995,686	4,886,150	0.408437	73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	10,036,482	9,778,009	1.026434	88.00
90.00	09000	CLINIC	203,124	308,027	0.659436	90.00
91.00	09100	EMERGENCY	3,197,714	4,647,218	0.688092	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	446,580	1,270,870	0.351397	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	303,701	48,412	6.273259	93.01
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (sum of lines 50 thru 199)	28,427,131	70,943,226		200.00
201.00		Less Observation Beds	446,580	0		201.00
202.00		Total (line 200 minus line 201)	27,980,551	70,943,226		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
5/24/2022 8:35 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	290,028	8,472,950	0.034230	549,434	18,807
52.00	05200	DELIVERY ROOM & LABOR ROOM	54,337	292,661	0.185665	0	0
53.00	05300	ANESTHESIOLOGY	3,361	3,260,207	0.001031	159,958	165
54.00	05400	RADIOLOGY-DIAGNOSTIC	310,882	14,922,722	0.020833	323,616	6,742
56.00	05600	RADIOISOTOPE	23,903	649,145	0.036822	6,212	229
60.00	06000	LABORATORY	184,000	16,405,238	0.011216	569,887	6,392
60.02	06002	GEO PSYCH	19,424	283,426	0.068533	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,323	103,066	0.022539	19,558	441
65.00	06500	RESPIRATORY THERAPY	54,085	1,779,685	0.030390	427,634	12,996
66.00	06600	PHYSICAL THERAPY	21,391	832,186	0.025705	138,886	3,570
69.00	06900	ELECTROCARDIOLOGY	68,006	905,959	0.075065	11,276	846
69.01	06901	PULMONARY REHAB	17,108	294,994	0.057994	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,343	850,276	0.023925	42,110	1,007
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,121	952,025	0.012732	242,078	3,082
73.00	07300	DRUGS CHARGED TO PATIENTS	117,571	4,886,150	0.024062	760,905	18,309
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	452,174	9,778,009	0.046244	0	0
90.00	09000	CLINIC	16,177	308,027	0.052518	63	3
91.00	09100	EMERGENCY	180,647	4,647,218	0.038872	84,034	3,267
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	64,765	1,270,870	0.050961	8,556	436
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0
93.01	04950	DIABETIC EDUCATION	17,019	48,412	0.351545	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)	1,929,665	70,943,226		3,344,207	76,292

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,093,053	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	0	0	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,093,053	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description			Title XVIII		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	8,472,950	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	292,661	0.000000
53.00	05300	ANESTHESIOLOGY	0	1,093,053	0	3,260,207	0.335271
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,922,722	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	649,145	0.000000
60.00	06000	LABORATORY	0	0	0	16,405,238	0.000000
60.02	06002	GEO PSYCH	0	0	0	283,426	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	103,066	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,779,685	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	832,186	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	905,959	0.000000
69.01	06901	PULMONARY REHAB	0	0	0	294,994	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	850,276	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	952,025	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,886,150	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	9,778,009	0.000000
90.00	09000	CLINIC	0	0	0	308,027	0.000000
91.00	09100	EMERGENCY	0	0	0	4,647,218	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,270,870	0.000000
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000
93.01	04950	DIABETIC EDUCATION	0	0	0	48,412	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000
200.00		Total (lines 50 through 199)	0	1,093,053	0	70,943,226	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1305

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2022 8:35 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	549,434	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	159,958	53,629	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	323,616	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.000000	6,212	0	0	0	56.00
60.00	06000 LABORATORY	0.000000	569,887	0	0	0	60.00
60.02	06002 GEO PSYCH	0.000000	0	0	0	0	60.02
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	19,558	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.000000	427,634	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	138,886	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	11,276	0	0	0	69.00
69.01	06901 PULMONARY REHAB	0.000000	0	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	42,110	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	242,078	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	760,905	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000 CLINIC	0.000000	63	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	84,034	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	8,556	0	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04950 DIABETIC EDUCATION	0.000000	0	0	0	0	93.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		3,344,207	53,629	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/24/2022 8:35 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	0.303604	0	1,977,079	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.893296	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.343377	0	822,715	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164482	0	4,854,868	0	0	54.00
56.00	05600	RADIOISOTOPE	0.454815	0	310,379	0	0	56.00
60.00	06000	LABORATORY	0.206683	0	5,173,284	0	0	60.00
60.02	06002	GEO PSYCH	0.697699	0	258,650	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.976491	0	49,267	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.329329	0	318,213	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.359946	0	111,822	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.285981	0	304,537	0	0	69.00
69.01	06901	PULMONARY REHAB	0.371360	0	205,644	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.103795	0	121,827	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.534800	0	162,058	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.408437	0	1,105,569	185	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.659436	0	186,799	0	0	90.00
91.00	09100	EMERGENCY	0.688092	0	1,259,793	125,851	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.351397	0	419,342	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	6.273259	0	17,281	0	0	93.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	17,659,127	126,036	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	17,659,127	126,036	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/24/2022 8:35 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	600,249	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	282,501	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	798,538	0	54.00
56.00	05600	RADIOISOTOPE	141,165	0	56.00
60.00	06000	LABORATORY	1,069,230	0	60.00
60.02	06002	GEO PSYCH	180,460	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	48,109	0	62.00
65.00	06500	RESPIRATORY THERAPY	104,797	0	65.00
66.00	06600	PHYSICAL THERAPY	40,250	0	66.00
69.00	06900	ELECTROCARDIOLOGY	87,092	0	69.00
69.01	06901	PULMONARY REHAB	76,368	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,645	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	86,669	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	451,555	76	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	123,182	0	90.00
91.00	09100	EMERGENCY	866,853	86,597	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	147,356	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04950	DIABETIC EDUCATION	108,408	0	93.01
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	5,225,427	86,673	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	5,225,427	86,673	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1305
Component CCN: 14-Z305

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description			Title XVIII		Swing Beds - SNF		Cost	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,093,053	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	0	0	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,093,053	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1305 Component CCN: 14-Z305		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/24/2022 8:35 am	
			Title XVIII		Swing Beds - SNF		Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	8,472,950	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	292,661	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	1,093,053	0	3,260,207	0.335271	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,922,722	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	649,145	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	16,405,238	0.000000	60.00
60.02	06002	GEO PSYCH	0	0	0	283,426	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	103,066	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,779,685	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	832,186	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	905,959	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	0	0	294,994	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	850,276	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	952,025	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,886,150	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	9,778,009	0.000000	88.00
90.00	09000	CLINIC	0	0	0	308,027	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	4,647,218	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,270,870	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	48,412	0.000000	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
200.00		Total (lines 50 through 199)	0	1,093,053	0	70,943,226		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1305

Period:

Worksheet D

Component CCN: 14-Z305

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

Part IV
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Cost
		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
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	53,029	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000 LABORATORY	0.000000	126,549	0	0	0	60.00
60.02	06002 GEO PSYCH	0.000000	0	0	0	0	60.02
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	3,270	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.000000	188,327	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	419,620	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	4,248	0	0	0	69.00
69.01	06901 PULMONARY REHAB	0.000000	0	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	16,426	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	405,963	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	4,476	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04950 DIABETIC EDUCATION	0.000000	0	0	0	0	93.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		1,221,908	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1305

Period:

Worksheet D

Component CCN: 14-Z305

From 01/01/2021
To 12/31/2021Part V
Date/Time Prepared:
5/24/2022 8:35 am

			Title XVIII		Swing Beds - SNF		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	0.303604	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.893296	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.343377	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164482	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.454815	0	0	0	0	56.00
60.00	06000	LABORATORY	0.206683	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0.697699	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.976491	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.329329	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.359946	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.285981	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0.371360	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.103795	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.534800	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.408437	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.659436	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.688092	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.351397	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	6.273259	0	0	0	0	93.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	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	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1305

Period:

Worksheet D

Component CCN: 14-Z305

From 01/01/2021
To 12/31/2021Part V
Date/Time Prepared:
5/24/2022 8:35 am

			Title XVIII		Swing Beds - SNF		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	0	0				50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00	05300	ANESTHESIOLOGY	0	0				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0				54.00
56.00	05600	RADIOISOTOPE	0	0				56.00
60.00	06000	LABORATORY	0	0				60.00
60.02	06002	GEO PSYCH	0	0				60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
65.00	06500	RESPIRATORY THERAPY	0	0				65.00
66.00	06600	PHYSICAL THERAPY	0	0				66.00
69.00	06900	ELECTROCARDIOLOGY	0	0				69.00
69.01	06901	PULMONARY REHAB	0	0				69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0				73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0	0				90.00
91.00	09100	EMERGENCY	0	0				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0				93.00
93.01	04950	DIABETIC EDUCATION	0	0				93.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0					95.00
200.00		Subtotal (see instructions)	0	0				200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00		Net Charges (line 200 - line 201)	0	0				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
5/24/2022 8:35 am

			Title XIX		Hospital	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		714,162	217,554	496,608	1,938	256.25	30.00
43.00	NURSERY		27,107		27,107	185	146.52	43.00
200.00	Total (lines 30 through 199)		741,269		523,715	2,123		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		176	45,100				
43.00	NURSERY		97	14,212				
200.00	Total (lines 30 through 199)		273	59,312	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description			Title XIX		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	290,028	8,472,950	0.034230	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	54,337	292,661	0.185665	0	0 52.00
53.00	05300	ANESTHESIOLOGY	3,361	3,260,207	0.001031	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	310,882	14,922,722	0.020833	0	0 54.00
56.00	05600	RADIOISOTOPE	23,903	649,145	0.036822	0	0 56.00
60.00	06000	LABORATORY	184,000	16,405,238	0.011216	0	0 60.00
60.02	06002	GEO PSYCH	19,424	283,426	0.068533	0	0 60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,323	103,066	0.022539	0	0 62.00
65.00	06500	RESPIRATORY THERAPY	54,085	1,779,685	0.030390	0	0 65.00
66.00	06600	PHYSICAL THERAPY	21,391	832,186	0.025705	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	68,006	905,959	0.075065	0	0 69.00
69.01	06901	PULMONARY REHAB	17,108	294,994	0.057994	0	0 69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,343	850,276	0.023925	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,121	952,025	0.012732	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	117,571	4,886,150	0.024062	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	452,174	9,778,009	0.046244	0	0 88.00
90.00	09000	CLINIC	16,177	308,027	0.052518	0	0 90.00
91.00	09100	EMERGENCY	180,647	4,647,218	0.038872	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	64,765	1,270,870	0.050961	0	0 92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0 93.00
93.01	04950	DIABETIC EDUCATION	17,019	48,412	0.351545	0	0 93.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	1,929,665	70,943,226		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1305		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 5/24/2022 8:35 am	
					Title XIX		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
43.00	04300	NURSERY	0	0	0	0	0	43.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	1,938	0.00	176	30.00		
43.00	04300	NURSERY		0	185	0.00	97	43.00		
200.00		Total (lines 30 through 199)		0	2,123		273	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
43.00	04300	NURSERY	0						43.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1305		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/24/2022 8:35 am	
				Title XIX		Hospital		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,093,053	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
60.02	06002	GEO PSYCH		0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB		0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER		0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION		0	0	0	0	0	93.01
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)	1,093,053	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1305		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/24/2022 8:35 am	
			Title XIX		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	8,472,950	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	292,661	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	1,093,053	0	3,260,207	0.335271	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,922,722	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	649,145	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	16,405,238	0.000000	60.00
60.02	06002	GEO PSYCH	0	0	0	283,426	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	103,066	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,779,685	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	832,186	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	905,959	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	0	0	294,994	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	850,276	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	952,025	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,886,150	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	9,778,009	0.000000	88.00
90.00	09000	CLINIC	0	0	0	308,027	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	4,647,218	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,270,870	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	48,412	0.000000	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
200.00		Total (lines 50 through 199)	0	1,093,053	0	70,943,226		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1305

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description		Title XIX			Hospital		PPS	
		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0.000000	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	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	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0.000000	0	0	0	0	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1305	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/24/2022 8:35 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)		2,817	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,938	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,685	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		849	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		30	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		900	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)		782	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			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		164.73	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		164.73	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,924,392	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)		4,942	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		1,503,546	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,420,846	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)		3,420,846	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)		1,765.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,588,626	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,588,626	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1305

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

Worksheet D-1

Date/Time Prepared:
5/24/2022 8:35 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)	0	0	0.00	0	0	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)					1,114,210	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,702,836	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)					1,380,339	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,380,339	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)					253	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,765.14	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					446,580	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1305

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

Worksheet D-1

Date/Time Prepared:
5/24/2022 8:35 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	714,162	4,924,392	0.145025	446,580	64,765
91.00	Nursing Program cost	0	4,924,392	0.000000	446,580	0
92.00	Allied health cost	0	4,924,392	0.000000	446,580	0
93.00	All other Medical Education	0	4,924,392	0.000000	446,580	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1305	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/24/2022 8:35 am
Title XIX		Hospital	PPS	
Cost Center Description		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,817	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,938	2.00	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00	
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,685	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	849	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	30	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	176	9.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00	
15.00	Total nursery days (title V or XIX only)	185	15.00	
16.00	Nursery days (title V or XIX only)	97	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	0.00	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00	
21.00	Total general inpatient routine service cost (see instructions)	4,924,392	21.00	
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00	
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00	
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00	
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00	
26.00	Total swing-bed cost (see instructions)	1,500,107	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,424,285	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)	3,424,285	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)	1,766.92	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)	310,978	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)	310,978	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1305

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

Worksheet D-1

Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description		Title XIX		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	609,299	185	3,293.51	97	319,470
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					630,448
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					59,312
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					59,312
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					571,136
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00	Program routine service cost (line 9 x line 71)					
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00	Per diem capital-related costs (line 75 ÷ line 2)					
77.00	Program capital-related costs (line 9 x line 76)					
78.00	Inpatient routine service cost (line 74 minus line 77)					
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00	Inpatient routine service cost per diem limitation					
82.00	Inpatient routine service cost limitation (line 9 x line 81)					
83.00	Reasonable inpatient routine service costs (see instructions)					
84.00	Program inpatient ancillary services (see instructions)					
85.00	Utilization review - physician compensation (see instructions)					
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					253
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,766.92
89.00	Observation bed cost (line 87 x line 88) (see instructions)					447,031

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1305

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

Worksheet D-1

Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	714,162	4,924,392	0.145025	447,031	64,831
91.00	Nursing Program cost	0	4,924,392	0.000000	447,031	0
92.00	Allied health cost	0	4,924,392	0.000000	447,031	0
93.00	All other Medical Education	0	4,924,392	0.000000	447,031	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1305	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/24/2022 8:35 am	
		Title XVIII	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,603,724		30.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.303604	549,434	166,810	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.893296	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.343377	159,958	54,926	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.164482	323,616	53,229	54.00
56.00	05600 RADIOISOTOPE	0.454815	6,212	2,825	56.00
60.00	06000 LABORATORY	0.206683	569,887	117,786	60.00
60.02	06002 GEO PSYCH	0.697699	0	0	60.02
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.976491	19,558	19,098	62.00
65.00	06500 RESPIRATORY THERAPY	0.329329	427,634	140,832	65.00
66.00	06600 PHYSICAL THERAPY	0.359946	138,886	49,991	66.00
69.00	06900 ELECTROCARDIOLOGY	0.285981	11,276	3,225	69.00
69.01	06901 PULMONARY REHAB	0.371360	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.103795	42,110	4,371	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.534800	242,078	129,463	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.408437	760,905	310,782	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.659436	63	42	90.00
91.00	09100 EMERGENCY	0.688092	84,034	57,823	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.351397	8,556	3,007	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.01	04950 DIABETIC EDUCATION	6.273259	0	0	93.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,344,207	1,114,210	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		3,344,207		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1305 Component CCN: 14-Z305	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/24/2022 8:35 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.303604	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.893296	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.343377	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.164482	53,029	8,722	54.00
56.00	05600 RADIOISOTOPE	0.454815	0	0	56.00
60.00	06000 LABORATORY	0.206683	126,549	26,156	60.00
60.02	06002 GEO PSYCH	0.697699	0	0	60.02
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.976491	3,270	3,193	62.00
65.00	06500 RESPIRATORY THERAPY	0.329329	188,327	62,022	65.00
66.00	06600 PHYSICAL THERAPY	0.359946	419,620	151,041	66.00
69.00	06900 ELECTROCARDIOLOGY	0.285981	4,248	1,215	69.00
69.01	06901 PULMONARY REHAB	0.371360	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.103795	16,426	1,705	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.534800	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.408437	405,963	165,810	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.659436	0	0	90.00
91.00	09100 EMERGENCY	0.688092	4,476	3,080	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.351397	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.01	04950 DIABETIC EDUCATION	6.273259	0	0	93.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,221,908	422,944	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,221,908		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1305	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/24/2022 8:35 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,312,100 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)			5,312,100 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			5,365,221 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)			51,585 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			2,487,071 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)			2,826,565 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)			2,826,565 30.00
31.00	Primary payer payments			1,269 31.00
32.00	Subtotal (line 30 minus line 31)			2,825,296 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)			315,586 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			205,131 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			219,452 36.00
37.00	Subtotal (see instructions)			3,030,427 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			3,030,427 40.00
40.01	Sequestration adjustment (see instructions)			0 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
40.03	Sequestration adjustment-PARHM pass-throughs			0 40.03
41.00	Interim payments			4,040,957 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)			-1,010,530 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: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part I
Date/Time Prepared:
5/24/2022 8:35 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		2,156,433		4,041,157	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	09/16/2021	32,809	09/16/2021	200	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-32,809		-200	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,123,624		4,040,957	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		351,810		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1,010,530	6.02
7.00	Total Medicare program liability (see instructions)		2,475,434		3,030,427	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: 14-1305

Period:

Worksheet E-1

Component CCN: 14-Z305

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
5/24/2022 8:35 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,799,220		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	09/16/2021	111,652		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-111,652		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,687,568		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		118,350		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,805,918		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: 14-1305	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/24/2022 8:35 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 (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168				7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1305

Period:

Worksheet E-2

Component CCN: 14-Z305

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 8:35 am

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,394,142	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)		427,173	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		782	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,821,315	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,821,315	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,821,315	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		15,397	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,805,918	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,805,918	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		1,687,568	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)		118,350	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: 14-1305	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prepared: 5/24/2022 8:35 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,702,836	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)		2,702,836	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,729,864	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)		2,729,864	19.00
20.00	Deductibles (exclude professional component)		278,992	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,450,872	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		2,450,872	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		37,787	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		24,562	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		30,088	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,475,434	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.98	Recovery of accelerated depreciation.		0	29.98
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		2,475,434	30.00
30.01	Sequestration adjustment (see instructions)		0	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM			30.03
31.00	Interim payments		2,123,624	31.00
31.01	Interim payments-PARHM			31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)			32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		351,810	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1305

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

Worksheet G

Date/Time Prepared: 5/24/2022 8:35 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	15,218,771	0	0	0	1.00
2.00	Temporary investments	46,443	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,927,727	0	0	0	4.00
5.00	Other receivable	1,325,966	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	435,994	0	0	0	7.00
8.00	Prepaid expenses	352,933	0	0	0	8.00
9.00	Other current assets	17,749	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	25,325,583	0	0	0	11.00
FIXED ASSETS						
12.00	Land	514,957	0	0	0	12.00
13.00	Land improvements	1,402,947	0	0	0	13.00
14.00	Accumulated depreciation	-712,079	0	0	0	14.00
15.00	Buildings	26,897,248	0	0	0	15.00
16.00	Accumulated depreciation	-15,279,637	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	9,328,544	0	0	0	23.00
24.00	Accumulated depreciation	-6,201,568	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	1,968,769	0	0	0	27.00
28.00	Accumulated depreciation	-1,968,769	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)	15,950,412	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	7,611,622	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	1,064,536	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,676,158	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	49,952,153	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,730,465	0	0	0	37.00
38.00	Salaries, wages, and fees payable	828,530	0	0	0	38.00
39.00	Payroll taxes payable	133,411	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,164,477	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	1,492,569	0	0	0	43.00
44.00	Other current liabilities	295,816	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,645,268	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	17,841,290	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	291,092	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18,132,382	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,777,650	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	24,174,503				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	24,174,503	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	49,952,153	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1305

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

Worksheet G-1

Date/Time Prepared:
5/24/2022 8:35 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		12,831,030		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11,171,630				2.00
3.00	Total (sum of line 1 and line 2)		24,002,660		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	RESTRICTED CONTRIBUTIONS	171,843		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)		171,843		0		10.00
11.00	Subtotal (line 3 plus line 10)		24,174,503		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		24,174,503		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	RESTRICTED CONTRIBUTIONS		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1305

Period:
From 01/01/2021
To 12/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
5/24/2022 8:35 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,765,856		4,765,856	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,765,856		4,765,856	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)	4,765,856		4,765,856	17.00
18.00	Ancillary services	8,322,731	46,192,023	54,514,754	18.00
19.00	Outpatient services	227,307	14,806,790	15,034,097	19.00
20.00	RURAL HEALTH CLINIC	0	9,783,810	9,783,810	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICE	0	1,003,202	1,003,202	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,315,894	71,785,825	85,101,719	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,196,977		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)		38,196,977		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1305

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

Worksheet G-3

Date/Time Prepared:
5/24/2022 8:35 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	85,101,719	1.00
2.00	Less contractual allowances and discounts on patients' accounts	45,484,497	2.00
3.00	Net patient revenues (line 1 minus line 2)	39,617,222	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,196,977	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,420,245	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	120,262	6.00
7.00	Income from investments	674,220	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	28,197	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	67,256	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	7,161	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	63,839	22.00
23.00	Governmental appropriations	143,323	23.00
24.00	HOSPITAL OTHER INCOME	230,078	24.00
24.01	EQUITY EARNINGS ON INVESTMENTS	0	24.01
24.02	OTHER (SPECIFY)	0	24.02
24.03	RELEASED FROM RESTRICTION	0	24.03
24.04	340B PHARMACY REVENUE	1,180,040	24.04
24.05	SALARY REIMBURSEMENTS	34,188	24.05
24.06	GAIN ON EXTINGUISHMENT OF PPP LOAN	2,656,143	24.06
24.07	EQUITY IN EARNINGS OF UNCONSOLIDATED	71,700	24.07
24.50	COVID-19 PHE Funding	4,478,904	24.50
25.00	Total other income (sum of lines 6-24)	9,755,311	25.00
26.00	Total (line 5 plus line 25)	11,175,556	26.00
27.00	LOSS ON DISPOSAL	3,926	27.00
27.01	EQUITY IN EARNINGS OF UNCONSOLIDATED	0	27.01
27.02	OTHER LOSS ON DISPOSAL	0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	3,926	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	11,171,630	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1305

Period:

Worksheet M-1

Component CCN: 14-3456

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

Date/Time Prepared:

5/24/2022 8:35 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	2,383,903	0	2,383,903	-870,229	1,513,674 1.00
2.00	Physician Assistant	262,721	0	262,721	-105	262,616 2.00
3.00	Nurse Practitioner	1,055,512	0	1,055,512	-7,072	1,048,440 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	0	0	0	0	0 5.00
6.00	Clinical Psychologist	0	0	0	0	0 6.00
7.00	Clinical Social Worker	0	0	0	0	0 7.00
8.00	Laboratory Technician	0	0	0	0	0 8.00
9.00	Other Facility Health Care Staff Costs	2,243,389	0	2,243,389	17,459	2,260,848 9.00
10.00	Subtotal (sum of lines 1 through 9)	5,945,525	0	5,945,525	-859,947	5,085,578 10.00
11.00	Physician Services Under Agreement	0	0	0	0	0 11.00
12.00	Physician Supervision Under Agreement	0	214,665	214,665	0	214,665 12.00
13.00	Other Costs Under Agreement	0	110,050	110,050	0	110,050 13.00
14.00	Subtotal (sum of lines 11 through 13)	0	324,715	324,715	0	324,715 14.00
15.00	Medical Supplies	0	551,006	551,006	0	551,006 15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0 16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00	Professional Liability Insurance	0	139,091	139,091	0	139,091 18.00
19.00	Other Health Care Costs	0	189,746	189,746	0	189,746 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	879,843	879,843	0	879,843 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	5,945,525	1,204,558	7,150,083	-859,947	6,290,136 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0 23.00
24.00	Dental	0	0	0	0	0 24.00
25.00	Optometry	0	0	0	0	0 25.00
25.01	Telehealth	0	0	0	13,614	13,614 25.01
25.02	Chronic Care Management	0	0	0	0	0 25.02
26.00	All other nonreimbursable costs	0	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	13,614	13,614 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	93,837	93,837	0	93,837 29.00
30.00	Administrative Costs	0	0	0	0	0 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	93,837	93,837	0	93,837 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,945,525	1,298,395	7,243,920	-846,333	6,397,587 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1305

Period:

Worksheet M-1

Component CCN: 14-3456

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 8:35 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	1,513,674	1.00
2.00	Physician Assistant	0	262,616	2.00
3.00	Nurse Practitioner	0	1,048,440	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	2,260,848	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	5,085,578	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	214,665	12.00
13.00	Other Costs Under Agreement	0	110,050	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	324,715	14.00
15.00	Medical Supplies	0	551,006	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	-24,137	114,954	18.00
19.00	Other Health Care Costs	-48,202	141,544	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	-72,339	807,504	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-72,339	6,217,797	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	13,614	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	13,614	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	93,837	29.00
30.00	Administrative Costs	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	93,837	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-72,339	6,325,248	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1305

Period:

Worksheet M-2

Component CCN: 14-3456

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

Date/Time Prepared:

5/24/2022 8:35 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	3.17	12,046	4,200	13,314		1.00
2.00	Physician Assistant	1.22	4,928	2,100	2,562		2.00
3.00	Nurse Practitioner	4.67	15,519	2,100	9,807		3.00
4.00	Subtotal (sum of lines 1 through 3)	9.06	32,493		25,683	32,493	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	9.06	32,493			32,493	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)					6,217,797	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					13,614	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					6,231,411	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.997815	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					93,837	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,711,234	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,805,071	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					3,805,071	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,796,757	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					10,014,554	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1305 Component CCN: 14-3456	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/24/2022 8:35 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)			10,014,554	1.00	
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			185,195	2.00	
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			9,829,359	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			32,493	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)			32,493	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			302.51	7.00	
			Calculation of Limit (1)			
			Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			87.52	306.88	8.00
9.00	Rate for Program covered visits (see instructions)			302.51	302.51	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			1,593	4,761	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			481,898	1,440,250	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	1,922,148	16.00
16.01	Total program charges (see instructions)(from contractor's records)				1,640,277	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				209,247	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				245,205	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.)				1,232,451	16.04
16.05	Total program cost (see instructions)			0	1,477,656	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				136,379	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				258,897	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				1,477,656	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				59,878	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				1,537,534	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)				1,537,534	26.00
26.01	Sequestration adjustment (see instructions)				0	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				1,416,829	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)				120,705	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: 14-1305

Period:

Worksheet M-4

Component CCN: 14-3456

From 01/01/2021

Date/Time Prepared:

To 12/31/2021

5/24/2022 8:35 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)	5,085,578	5,085,578	5,085,578	5,085,578	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000240	0.000652	0.001536	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,221	3,316	7,811	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	56,470	46,167	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	57,691	49,483	7,811	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	6,217,797	6,217,797	6,217,797	6,217,797	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	3,796,757	3,796,757	3,796,757	3,796,757	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.009278	0.007958	0.001256	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	35,226	30,215	4,769	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	92,917	79,698	12,580	0	10.00
11.00	Total number of injections/infusions (from your records)	366	995	2,343	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	253.87	80.10	5.37	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	115	326	669	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			182	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)	29,195	26,113	4,570	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)		185,195			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		59,878			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1305 Component CCN: 14-3456	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/24/2022 8:35 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		1,327,980	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		09/16/2021	88,849	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)		88,849	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,416,829	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		120,705	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,537,534	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00