

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: 14-1308	Period: From 05/01/2020 To 04/30/2021	Worksheet S Parts I-III Date/Time Prepared: 9/28/2021 12:57 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 9/28/2021	Time: 12:57 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WASHINGTON COUNTY HOSPITAL (14-1308) for the cost reporting period beginning 05/01/2020 and ending 04/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-16,123	607,858	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	133,155	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		97,904		0	10.00
200.00	Total	0	117,032	705,762	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: 14-1308		Period: From 05/01/2020 To 04/30/2021		Worksheet S-2 Part I Date/Time Prepared: 9/28/2021 12:57 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 705 SOUTH GRAND AVENUE			PO Box:				1.00		
2.00	City: NASHVILLE			State: IL		Zip Code: 62263		County: WASHINGTON		
		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		WASHINGTON COUNTY HOSPITAL	141308	99914	1	12/01/2000	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		WASHINGTON COUNTY SWING BED	14Z308	99914		08/18/2000	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC		WASHINGTON COUNTY EXTENDED CARE							
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		GRAND STREET RHC	143472	99914		08/01/2005	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						05/01/2020	04/30/2021		20.00
21.00	Type of Control (see instructions)						11			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00

Worksheet S-2
Part I
Date/Time Prepared:
9/28/2021 12:57 pm

MCRIF32 - 16.12.172.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1308		Period: From 05/01/2020 To 04/30/2021		Worksheet S-2 Part I Date/Time Prepared: 9/28/2021 12:57 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					0.00	62.00
62.01	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	62.01
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)						
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00
						0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part I
Date/Time Prepared:
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1308	Period: From 05/01/2020 To 04/30/2021	Worksheet S-2 Part I Date/Time Prepared: 9/28/2021 12:57 pm
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			1.00		
	Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete worksheet E, Part A, lines 200 through 218, and worksheet E-2, lines 200 through 215, as applicable.			N	110.00

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		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:	47,327	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1308		Period: From 05/01/2020 To 04/30/2021		Worksheet S-2 Part I Date/Time Prepared: 9/28/2021 12:57 pm	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y	144.00
						1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						146.00
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					Y	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					N	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)					Y	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1308	Period: From 05/01/2020 To 04/30/2021	Worksheet S-2 Part II Date/Time Prepared: 9/28/2021 12:57 pm
			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.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
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)	Y	08/16/2021	Y 08/16/2021
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: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part II
Date/Time Prepared:
9/28/2021 12:57 pm

		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.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JENNIFER	VENABLE		41.00
42.00	Enter the employer/company name of the cost report preparer.	WASHINGTON COUNTY HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-327-2369	JVENABLE@WASHINGTONCOUNTYHOSPITAL.0R		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part II
Date/Time Prepared:
9/28/2021 12:57 pm

		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: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
9/28/2021 12:57 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,030	3,054.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		22	8,030	3,054.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		22	8,030	3,054.00	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	28	10,220			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	115.00					23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		50				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: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
9/28/2021 12:57 pm

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)	155	0	212			1.00
2.00	HMO and other (see instructions)	0	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	899	0	1,117			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	282			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,054	0	1,611			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)	1,054	0	1,611	0.00	87.95	14.00
15.00	CAH visits	8,870	238	24,628			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			6,570	0.00	15.04	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				0.00	0.00	23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,129	0	7,575	0.00	11.06	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	114.05	27.00
28.00	Observation Bed Days		0	120			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
9/28/2021 12:57 pm

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	43	0	61	1.00
2.00 HMO and other (see instructions)			0	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	43	0	61	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				24	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	0.00					23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		WASHINGTON COUNTY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1308 Component CCN: 14-3472		Period: From 05/01/2020 To 04/30/2021 Worksheet S-8 Date/Time Prepared: 9/28/2021 12:57 pm	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	705 SOUTH GRAND AVE		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	NASHVILLE		IL 62263	2.00
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	07:30		19:00	07:30
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	WASHINGTON		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	19:00	07:30	19:00	07:30
		19:00	07:30	19:00	07:30

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1308

Period:

Worksheet S-8

Component CCN: 14-3472

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 12:57 pm

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	07:30	19:00	08:00	14:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet S-10

Date/Time Prepared:
9/28/2021 12:57 pm

			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)		0.747174	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,123,209	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		2,210,072	6.00
7.00	Medicaid cost (line 1 times line 6)		1,651,308	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)		528,099	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)		528,099	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	50,955	13,356	64,311
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	38,072	13,356	51,428
22.00	Payments received from patients for amounts previously written off as charity care	50	120	170
23.00	Cost of charity care (line 21 minus line 22)	38,022	13,236	51,258
			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)		513,546	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		54,715	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		84,176	27.01
28.00	Non-Medicare bad debt expense (see instructions)		429,370	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		350,275	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		401,533	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		929,632	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet A

Date/Time Prepared:
9/28/2021 12:57 pm

	Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		217,739	217,739	22,311	240,050	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		140,797	140,797	0	140,797	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,195	1,620,292	1,636,487	0	1,636,487	4.00
5.01	00550	INFORMATION SYSTEMS	237,262	321,014	558,276	-50,200	508,076	5.01
5.02	00591	ADMITTING	179,593	12,319	191,912	0	191,912	5.02
5.03	00570	PATIENT ACCOUNTING	166,968	65,357	232,325	0	232,325	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	141,589	863,871	1,005,460	100,716	1,106,176	5.04
6.00	00600	MAINTENANCE & REPAIRS	108,979	432,943	541,922	-2,490	539,432	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	138,719	138,719	0	138,719	8.00
9.00	00900	HOUSEKEEPING	237,294	29,326	266,620	0	266,620	9.00
10.00	01000	DIETARY	242,407	99,806	342,213	-36,194	306,019	10.00
11.00	01100	CAFETERIA	0	0	0	36,194	36,194	11.00
13.00	01300	NURSING ADMINISTRATION	2,795	136	2,931	0	2,931	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	58,702	5,117	63,819	0	63,819	14.00
15.00	01500	PHARMACY	146,297	31,233	177,530	0	177,530	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	174,154	27,706	201,860	0	201,860	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	6,269	6,269	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	40,800	40,800	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	750,180	286,478	1,036,658	-49,444	987,214	30.00
46.00	04600	OTHER LONG TERM CARE	601,647	77,761	679,408	0	679,408	46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	122,244	90,737	212,981	0	212,981	50.00
53.00	05300	ANESTHESIOLOGY	0	47,635	47,635	-40,800	6,835	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	272,126	355,132	627,258	50,200	677,458	54.00
60.00	06000	LABORATORY	387,322	701,482	1,088,804	0	1,088,804	60.00
65.00	06500	RESPIRATORY THERAPY	2,054	29,977	32,031	0	32,031	65.00
66.00	06600	PHYSICAL THERAPY	825,869	41,720	867,589	0	867,589	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	65,180	6,347	71,527	0	71,527	68.01
69.00	06900	ELECTROCARDIOLOGY	8,354	9,187	17,541	0	17,541	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	60,412	60,412	-14,185	46,227	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,185	14,185	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	710,468	710,468	0	710,468	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,005,293	273,056	1,278,349	-47,349	1,231,000	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	451,474	1,001,594	1,453,068	0	1,453,068	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	43,175	43,175	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		22,311	22,311	-22,311	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,203,978	7,720,672	13,924,650	50,877	13,975,527	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,106	3,106	0	3,106	190.00
190.01	19001	OUTPATIENT CLINIC	2,409	1,859	4,268	0	4,268	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	45,826	108,880	154,706	-50,877	103,829	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	6,252,213	7,834,517	14,086,730	0	14,086,730	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet A

Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	37,161	277,211	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	66,909	207,706	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,636,487	4.00
5.01	00550	INFORMATION SYSTEMS	0	508,076	5.01
5.02	00591	ADMITTING	0	191,912	5.02
5.03	00570	PATIENT ACCOUNTING	0	232,325	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,504,952	2,611,128	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	539,432	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	138,719	8.00
9.00	00900	HOUSEKEEPING	0	266,620	9.00
10.00	01000	DIETARY	0	306,019	10.00
11.00	01100	CAFETERIA	-9,437	26,757	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,931	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-679	63,140	14.00
15.00	01500	PHARMACY	0	177,530	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,295	194,565	16.00
17.00	01700	SOCIAL SERVICE	0	6,269	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	40,800	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	987,214	30.00
46.00	04600	OTHER LONG TERM CARE	0	679,408	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	212,981	50.00
53.00	05300	ANESTHESIOLOGY	0	6,835	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	677,458	54.00
60.00	06000	LABORATORY	0	1,088,804	60.00
65.00	06500	RESPIRATORY THERAPY	0	32,031	65.00
66.00	06600	PHYSICAL THERAPY	0	867,589	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
68.01	06801	CARDIAC REHAB	0	71,527	68.01
69.00	06900	ELECTROCARDIOLOGY	0	17,541	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	46,227	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,185	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-54,940	655,528	73.00
76.00	03480	ONCOLOGY	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-170,269	1,060,731	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-113,405	1,339,663	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	43,175	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,252,997	15,228,524	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,106	190.00
190.01	19001	OUTPATIENT CLINIC	0	4,268	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	190.02
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	103,829	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	1,252,997	15,339,727	200.00

RECLASSIFICATIONS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-6

Date/Time Prepared:
9/28/2021 12:57 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - RECLASSIFY CAFETERIA COSTS					
	CAFETERIA	11.00	25,638	10,556		1.00
	TOTALS		25,638	10,556		
1.00	B - RECLASS SOCIAL SERVICE COST					
	SOCIAL SERVICE	17.00	6,269	0		1.00
	TOTALS		6,269	0		
1.00	C - RECLASS PROFESSIONAL LIABILITY INSUR					
	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	47,349		1.00
	TOTALS		0	47,349		
1.00	D - RECLASSIFY XRAY DIRECTORS SALARY					
	RADIOLOGY-DIAGNOSTIC	54.00	50,200	0		1.00
	TOTALS		50,200	0		
1.00	E - RECLASSIFY ANESTHESIA PRO FEES					
	NONPHYSICIAN ANESTHETISTS	19.00	0	40,800		1.00
	TOTALS		0	40,800		
1.00	F - INTEREST EXPENSE					
	CAP REL COSTS-BLDG & FIXT	1.00	0	22,311		1.00
	TOTALS		0	22,311		
1.00	G - TO RECLASS INTEROCULAR LENS					
	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	14,185		1.00
	TOTALS		0	14,185		
1.00	H - MILL STREET CLINIC EXPENSES					
	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	53,367		1.00
2.00	MILL STREET CLINIC	194.00	1,425	1,065		2.00
	TOTALS		1,425	54,432		
1.00	I - RESTORIX (WOUND CARE)					
	OTHER OUTPATIENT SERVICE COST CENTER	93.00	0	43,175		1.00
	TOTALS		0	43,175		
500.00	Grand Total: Increases		83,532	232,808		500.00

RECLASSIFICATIONS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-6

Date/Time Prepared:
9/28/2021 12:57 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASSIFY CAFETERIA COSTS						
1.00	DIETARY	10.00	25,638	10,556	0		1.00
	TOTALS		25,638	10,556			
	B - RECLASS SOCIAL SERVICE COST						
1.00	ADULTS & PEDIATRICS	30.00	6,269	0	0		1.00
	TOTALS		6,269	0			
	C - RECLASS PROFESSIONAL LIABILITY INSUR						
1.00	RURAL HEALTH CLINIC	88.00	0	47,349	0		1.00
	TOTALS		0	47,349			
	D - RECLASSIFY XRAY DIRECTORS SALARY						
1.00	INFORMATION SYSTEMS	5.01	50,200	0	0		1.00
	TOTALS		50,200	0			
	E - RECLASSIFY ANESTHESIA PRO FEES						
1.00	ANESTHESIOLOGY	53.00	0	40,800	0		1.00
	TOTALS		0	40,800			
	F - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	22,311	9		1.00
	TOTALS		0	22,311			
	G - TO RECLASS INTEROCULAR LENS						
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	14,185	0		1.00
	PATIENTS						
	TOTALS		0	14,185			
	H - MILL STREET CLINIC EXPENSES						
1.00	MILL STREET CLINIC	194.00	0	53,367	0		1.00
2.00	MAINTENANCE & REPAIRS	6.00	1,425	1,065	0		2.00
	TOTALS		1,425	54,432			
	I - RESTORIX (WOUND CARE)						
1.00	ADULTS & PEDIATRICS	30.00	0	43,175	0		1.00
	TOTALS		0	43,175			
500.00	Grand Total: Decreases		83,532	232,808			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet A-7
Part I
Date/Time Prepared:
9/28/2021 12:57 pm

		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	62,855	0	0	0	0	1.00
2.00	Land Improvements	419,030	0	0	0	0	2.00
3.00	Buildings and Fixtures	9,559,209	173,865	0	173,865	0	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	5,361,311	272,064	0	272,064	0	6.00
7.00	HIT designated Assets	927,041	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,329,446	445,929	0	445,929	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	16,329,446	445,929	0	445,929	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	62,855	0				1.00
2.00	Land Improvements	419,030	0				2.00
3.00	Buildings and Fixtures	9,733,074	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	5,633,375	0				6.00
7.00	HIT designated Assets	927,041	0				7.00
8.00	Subtotal (sum of lines 1-7)	16,775,375	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	16,775,375	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet A-7
Part II
Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	217,739	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	140,797	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	358,536	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	217,739				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	140,797				2.00
3.00	Total (sum of lines 1-2)	0	358,536				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet A-7
Part III
Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	10,214,959	0	10,214,959	0.608926	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,560,416	0	6,560,416	0.391074	0	2.00
3.00	Total (sum of lines 1-2)	16,775,375	0	16,775,375	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	277,211	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	207,706	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	484,917	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	277,211	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	207,706	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	484,917	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8

Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-15,679	0OTHER ADMINISTRATIVE AND GENERAL	5.04	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-679	0CENTRAL SERVICES & SUPPLY	14.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		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	-113,405			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	0RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,636,562			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-9,437	0CAFETERIA	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	-7,295	0MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	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	0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	0NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0	0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0	0CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8

Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	MISCELLANEOUS REVENUE - OTHER	B	-2,672	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.01
34.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.00
35.00	EDUCATION FEES	B	0	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	35.00
36.00	NONALLOWABLE PUBLIC RELATIONS	A	-4,670	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	36.00
37.00	HEALTHLINK ADMIN FEES	A	11,337	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	37.00
38.00	LOBBYING PORTION OF DUES	A	-9,386	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	38.00
39.00	NON-RHC SERVICES	A	-163,058	RURAL HEALTH CLINIC	88.00	0	39.00
40.00	NON-RHC BENEFITS	A	-7,211	RURAL HEALTH CLINIC	88.00	0	40.00
41.00	TELEPHONE SERVICE	B	-6,470	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	42.00
43.00	340B PHARMACY	A	-54,940	DRUGS CHARGED TO PATIENTS	73.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,252,997				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: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8-1

Date/Time Prepared:
9/28/2021 12:57 pm

	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	5.00	04	OTHER ADMINISTRATIVE AND GEN	2,058,845	526,353	1.00
2.00	1.00		CAP REL COSTS-BLDG & FIXT	37,161	0	2.00
3.00	2.00		CAP REL COSTS-MVBLE EQUIP	66,909	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,162,915	526,353	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		0.00	SSM HEALTHCARE	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: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8-1

Date/Time Prepared:
9/28/2021 12:57 pm

	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	1,532,492	0		1.00
2.00	37,161	9		2.00
3.00	66,909	9		3.00
4.00	0	0		4.00
5.00	1,636,562			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	HEALTHCARE		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: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8-2

Date/Time Prepared:
9/28/2021 12:57 pm

	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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	21,349	0	21,349	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	968,748	113,405	855,343	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			990,097	113,405	876,692		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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0		3.00
4.00	91.00	EMERGENCY	0	0	0	113,405		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	113,405		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	INFORMATION SYSTEMS	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	277,211	277,211			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	207,706		207,706		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,636,487	708	0	1,637,195	4.00
5.01	00550	INFORMATION SYSTEMS	508,076	4,941	29,932	49,111	592,060
5.02	00591	ADMITTING	191,912	2,135	0	47,150	23,494
5.03	00570	PATIENT ACCOUNTING	232,325	4,984	0	43,836	37,591
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	2,611,128	18,690	0	37,173	32,892
6.00	00600	MAINTENANCE & REPAIRS	539,432	45,292	0	28,237	9,398
8.00	00800	LAUNDRY & LINEN SERVICE	138,719	3,216	0	0	0
9.00	00900	HOUSEKEEPING	266,620	2,103	0	62,299	9,398
10.00	01000	DIETARY	306,019	12,859	767	56,910	14,097
11.00	01100	CAFETERIA	26,757	3,903	0	6,731	0
13.00	01300	NURSING ADMINISTRATION	2,931	2,412	0	734	42,290
14.00	01400	CENTRAL SERVICES & SUPPLY	63,140	4,286	4,416	15,412	9,398
15.00	01500	PHARMACY	177,530	4,659	21,110	38,409	14,097
16.00	01600	MEDICAL RECORDS & LIBRARY	194,565	5,240	0	45,722	28,193
17.00	01700	SOCIAL SERVICE	6,269	447	0	1,646	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	40,800	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	987,214	26,933	10,705	195,306	28,193
46.00	04600	OTHER LONG TERM CARE	679,408	30,021	2,384	157,956	14,097
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	212,981	17,705	9,195	32,094	23,494
53.00	05300	ANESTHESIOLOGY	6,835	0	1,216	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	677,458	15,820	77,914	84,623	56,387
60.00	06000	LABORATORY	1,088,804	9,185	22,537	101,687	28,193
65.00	06500	RESPIRATORY THERAPY	32,031	527	3,140	539	0
66.00	06600	PHYSICAL THERAPY	867,589	13,557	3,780	216,823	70,483
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
68.01	06801	CARDIAC REHAB	71,527	2,162	5,184	17,112	9,398
69.00	06900	ELECTROCARDIOLOGY	17,541	256	2,636	2,193	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	46,227	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,185	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	655,528	0	0	0	0
76.00	03480	ONCOLOGY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,060,731	19,430	8,929	263,925	56,387
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	1,339,663	15,357	3,861	118,530	32,892
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	43,175	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,228,524	266,828	207,706	1,624,158	540,372
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,106	0	0	0	0
190.01	19001	OUTPATIENT CLINIC	4,268	10,383	0	632	37,591
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	MILL STREET CLINIC	103,829	0	0	12,405	14,097
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		TOTAL (sum lines 118 through 201)	15,339,727	277,211	207,706	1,637,195	592,060

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description			ADMITTING	PATIENT ACCOUNTING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	ADMITTING	264,691					5.02
5.03	00570	PATIENT ACCOUNTING	0	318,736				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	2,699,883	2,699,883		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	622,359	132,937	755,296	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	141,935	30,317	12,118	8.00
9.00	00900	HOUSEKEEPING	0	0	340,420	72,714	7,925	9.00
10.00	01000	DIETARY	0	0	390,652	83,444	48,451	10.00
11.00	01100	CAFETERIA	0	0	37,391	7,987	14,706	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	48,367	10,331	9,088	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	96,652	20,645	16,150	14.00
15.00	01500	PHARMACY	0	0	255,805	54,640	17,555	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	273,720	58,467	19,742	16.00
17.00	01700	SOCIAL SERVICE	0	0	8,362	1,786	1,685	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	40,800	8,715	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,793	21,425	1,287,569	275,026	101,477	30.00
46.00	04600	OTHER LONG TERM CARE	13,485	16,238	913,589	195,144	113,114	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,298	8,788	311,555	66,548	66,708	50.00
53.00	05300	ANESTHESIOLOGY	559	673	9,283	1,983	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,849	87,733	1,072,784	229,148	59,606	54.00
60.00	06000	LABORATORY	57,760	69,551	1,377,717	294,282	34,608	60.00
65.00	06500	RESPIRATORY THERAPY	1,121	1,350	38,708	8,268	1,986	65.00
66.00	06600	PHYSICAL THERAPY	34,808	41,914	1,248,954	266,778	51,079	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	1,260	1,517	108,160	23,103	8,145	68.01
69.00	06900	ELECTROCARDIOLOGY	2,734	3,292	28,652	6,120	963	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	517	623	47,367	10,118	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	877	1,056	16,118	3,443	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,533	21,112	694,173	148,276	0	73.00
76.00	03480	ONCOLOGY	611	735	1,346	288	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	17,416	20,971	1,447,789	309,249	73,208	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	18,070	21,758	1,550,131	331,108	57,860	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	43,175	9,222	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	264,691	318,736	15,153,416	2,660,087	716,174	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,106	663	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	0	52,874	11,294	39,122	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	0	130,331	27,839	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	264,691	318,736	15,339,727	2,699,883	755,296	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet B
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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	ADMITTING						5.02
5.03	00570	PATIENT ACCOUNTING						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	184,370					8.00
9.00	00900	HOUSEKEEPING	0	421,059				9.00
10.00	01000	DIETARY	0	27,747	550,294			10.00
11.00	01100	CAFETERIA	0	8,422	0	68,506		11.00
13.00	01300	NURSING ADMINISTRATION	0	5,205	0	43	73,034	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,249	0	1,178	0	14.00
15.00	01500	PHARMACY	0	10,053	0	996	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,305	0	3,126	0	16.00
17.00	01700	SOCIAL SERVICE	0	965	0	0	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	36,704	58,113	103,572	10,383	22,966	30.00
46.00	04600	OTHER LONG TERM CARE	121,242	64,776	433,753	13,024	28,748	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,709	38,202	0	1,593	3,470	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,217	34,135	0	4,148	0	54.00
60.00	06000	LABORATORY	0	19,819	0	5,871	0	60.00
65.00	06500	RESPIRATORY THERAPY	6	1,137	0	26	65	65.00
66.00	06600	PHYSICAL THERAPY	12,108	29,252	0	10,591	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	4,665	0	805	1,791	68.01
69.00	06900	ELECTROCARDIOLOGY	0	551	0	121	299	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	255	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	683	41,924	0	9,578	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	5,722	33,135	0	6,988	15,616	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	183,646	398,655	537,325	68,471	72,955	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	724	22,404	0	35	79	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	12,969	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	184,370	421,059	550,294	68,506	73,034	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet B
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Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
		14.00	15.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	INFORMATION SYSTEMS					5.01
5.02	00591	ADMITTING					5.02
5.03	00570	PATIENT ACCOUNTING					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	143,874				14.00
15.00	01500	PHARMACY	0	339,049			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	692	0	367,052		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	12,798	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	37,254	425	24,099	11,518	30.00
46.00	04600	OTHER LONG TERM CARE	33,496	0	0	1,280	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	14,274	0	50.00
53.00	05300	ANESTHESIOLOGY	1,765	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,329	275	44,120	0	54.00
60.00	06000	LABORATORY	7,643	118	64,698	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,506	0	5,376	0	65.00
66.00	06600	PHYSICAL THERAPY	3,164	796	28,548	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	2,903	0	2,966	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,287	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	337,126	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	9,498	102	128,841	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	20,632	207	41,710	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	143,169	339,049	354,632	12,798	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	247	0	7,044	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	458	0	5,376	0	194.00
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)	143,874	339,049	367,052	12,798	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	INFORMATION SYSTEMS				5.01
5.02	00591	ADMITTING				5.02
5.03	00570	PATIENT ACCOUNTING				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
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	1,969,106	-85,312	1,883,794	30.00
46.00	04600	OTHER LONG TERM CARE	1,918,166	0	1,918,166	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	504,059	0	504,059	50.00
53.00	05300	ANESTHESIOLOGY	62,546	0	62,546	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,452,762	0	1,452,762	54.00
60.00	06000	LABORATORY	1,804,756	0	1,804,756	60.00
65.00	06500	RESPIRATORY THERAPY	58,078	0	58,078	65.00
66.00	06600	PHYSICAL THERAPY	1,651,270	0	1,651,270	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
68.01	06801	CARDIAC REHAB	152,538	0	152,538	68.01
69.00	06900	ELECTROCARDIOLOGY	36,706	0	36,706	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,485	0	57,485	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,848	0	39,848	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,179,575	0	1,179,575	73.00
76.00	03480	ONCOLOGY	1,889	0	1,889	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,020,872	0	2,020,872	88.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	2,063,109	0	2,063,109	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	52,397	85,312	137,709	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE	0	0	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,025,162	0	15,025,162	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,769	0	3,769	190.00
190.01	19001	OUTPATIENT CLINIC	133,823	0	133,823	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	12,969	0	12,969	190.02
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	164,004	0	164,004	194.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	15,339,727	0	15,339,727	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	708	0	708	4.00
5.01	00550	INFORMATION SYSTEMS	0	4,941	29,932	34,873	5.01
5.02	00591	ADMITTING	0	2,135	0	2,135	5.02
5.03	00570	PATIENT ACCOUNTING	0	4,984	0	4,984	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	18,690	0	18,690	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	45,292	0	45,292	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,216	0	3,216	8.00
9.00	00900	HOUSEKEEPING	0	2,103	0	2,103	9.00
10.00	01000	DIETARY	0	12,859	767	13,626	10.00
11.00	01100	CAFETERIA	0	3,903	0	3,903	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,412	0	2,412	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,286	4,416	8,702	14.00
15.00	01500	PHARMACY	0	4,659	21,110	25,769	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,240	0	5,240	16.00
17.00	01700	SOCIAL SERVICE	0	447	0	447	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	26,933	10,705	37,638	30.00
46.00	04600	OTHER LONG TERM CARE	0	30,021	2,384	32,405	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	17,705	9,195	26,900	50.00
53.00	05300	ANESTHESIOLOGY	0	0	1,216	1,216	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,820	77,914	93,734	54.00
60.00	06000	LABORATORY	0	9,185	22,537	31,722	60.00
65.00	06500	RESPIRATORY THERAPY	0	527	3,140	3,667	65.00
66.00	06600	PHYSICAL THERAPY	0	13,557	3,780	17,337	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	2,162	5,184	7,346	68.01
69.00	06900	ELECTROCARDIOLOGY	0	256	2,636	2,892	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	19,430	8,929	28,359	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	15,357	3,861	19,218	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	266,828	207,706	474,534	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	10,383	0	10,383	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	277,211	207,706	484,917	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description			INFORMATION SYSTEMS	ADMITTING	PATIENT ACCOUNTING	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS	34,894					5.01
5.02	00591	ADMITTING	1,385	3,540				5.02
5.03	00570	PATIENT ACCOUNTING	2,215	0	7,218			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,939	0	0	20,645		5.04
6.00	00600	MAINTENANCE & REPAIRS	554	0	0	1,016	46,874	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	232	752	8.00
9.00	00900	HOUSEKEEPING	554	0	0	556	492	9.00
10.00	01000	DIETARY	831	0	0	638	3,007	10.00
11.00	01100	CAFETERIA	0	0	0	61	913	11.00
13.00	01300	NURSING ADMINISTRATION	2,492	0	0	79	564	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	554	0	0	158	1,002	14.00
15.00	01500	PHARMACY	831	0	0	418	1,089	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,662	0	0	447	1,225	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	14	105	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	67	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,662	238	485	2,103	6,298	30.00
46.00	04600	OTHER LONG TERM CARE	831	180	368	1,492	7,019	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,385	98	199	509	4,140	50.00
53.00	05300	ANESTHESIOLOGY	0	7	15	15	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,323	975	1,986	1,752	3,699	54.00
60.00	06000	LABORATORY	1,662	772	1,575	2,250	2,148	60.00
65.00	06500	RESPIRATORY THERAPY	0	15	31	63	123	65.00
66.00	06600	PHYSICAL THERAPY	4,152	465	949	2,040	3,170	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	554	17	34	177	506	68.01
69.00	06900	ELECTROCARDIOLOGY	0	37	75	47	60	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7	14	77	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12	24	26	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	234	478	1,134	0	73.00
76.00	03480	ONCOLOGY	0	8	17	2	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,323	233	475	2,364	4,543	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,939	242	493	2,533	3,591	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	71	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,848	3,540	7,218	20,341	44,446	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	5	0	190.00
190.01	19001	OUTPATIENT CLINIC	2,215	0	0	86	2,428	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	831	0	0	213	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	34,894	3,540	7,218	20,645	46,874	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	ADMITTING						5.02
5.03	00570	PATIENT ACCOUNTING						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,200					8.00
9.00	00900	HOUSEKEEPING	0	3,732				9.00
10.00	01000	DIETARY	0	246	18,373			10.00
11.00	01100	CAFETERIA	0	75	0	4,955		11.00
13.00	01300	NURSING ADMINISTRATION	0	46	0	3	5,596	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	82	0	85	0	14.00
15.00	01500	PHARMACY	0	89	0	72	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	100	0	226	0	16.00
17.00	01700	SOCIAL SERVICE	0	9	0	0	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	836	515	3,458	751	1,760	30.00
46.00	04600	OTHER LONG TERM CARE	2,762	572	14,482	942	2,202	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	39	339	0	115	266	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	119	303	0	300	0	54.00
60.00	06000	LABORATORY	0	176	0	425	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	10	0	2	5	65.00
66.00	06600	PHYSICAL THERAPY	276	259	0	766	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	41	0	58	137	68.01
69.00	06900	ELECTROCARDIOLOGY	0	5	0	9	23	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	6	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	16	372	0	693	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	130	294	0	505	1,197	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,184	3,533	17,940	4,952	5,590	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	16	199	0	3	6	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	433	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,200	3,732	18,373	4,955	5,596	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description			CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			14.00	15.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	ADMITTING						5.02
5.03	00570	PATIENT ACCOUNTING						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,590					14.00
15.00	01500	PHARMACY	0	28,285				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	51	0	8,971			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	576		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	67	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,741	35	589	518		30.00
46.00	04600	OTHER LONG TERM CARE	2,466	0	0	58		46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	349	0		50.00
53.00	05300	ANESTHESIOLOGY	130	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	245	23	1,078	0		54.00
60.00	06000	LABORATORY	563	10	1,581	0		60.00
65.00	06500	RESPIRATORY THERAPY	184	0	131	0		65.00
66.00	06600	PHYSICAL THERAPY	233	66	698	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
68.01	06801	CARDIAC REHAB	214	0	72	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,493	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	28,125	0	0		73.00
76.00	03480	ONCOLOGY	0	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	699	9	3,151	0		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	1,519	17	1,019	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0		93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,538	28,285	8,668	576	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
190.01	19001	OUTPATIENT CLINIC	18	0	172	0		190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0		190.02
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	MILL STREET CLINIC	34	0	131	0		194.00
200.00		Cross Foot Adjustments					67	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	10,590	28,285	8,971	576	67	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	INFORMATION SYSTEMS				5.01
5.02	00591	ADMITTING				5.02
5.03	00570	PATIENT ACCOUNTING				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
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	59,712	0	59,712	30.00
46.00	04600	OTHER LONG TERM CARE	65,848	0	65,848	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,353	0	34,353	50.00
53.00	05300	ANESTHESIOLOGY	1,383	0	1,383	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	107,574	0	107,574	54.00
60.00	06000	LABORATORY	42,928	0	42,928	60.00
65.00	06500	RESPIRATORY THERAPY	4,231	0	4,231	65.00
66.00	06600	PHYSICAL THERAPY	30,505	0	30,505	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
68.01	06801	CARDIAC REHAB	9,163	0	9,163	68.01
69.00	06900	ELECTROCARDIOLOGY	3,149	0	3,149	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	98	0	98	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,555	0	1,555	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,971	0	29,971	73.00
76.00	03480	ONCOLOGY	33	0	33	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	44,350	0	44,350	88.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	32,748	0	32,748	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	71	0	71	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	467,672	0	467,672	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5	0	5	190.00
190.01	19001	OUTPATIENT CLINIC	15,526	0	15,526	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	433	0	433	190.02
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	1,214	0	1,214	194.00
200.00		Cross Foot Adjustments	67	0	67	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	484,917	0	484,917	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	INFORMATION SYSTEMS (# OF COMPUTERS)	ADMITTING (GROSS REVENUES)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	52,060					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		142,086				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	133	0	6,236,018			4.00
5.01	00550	INFORMATION SYSTEMS	928	20,476	187,062	126		5.01
5.02	00591	ADMITTING	401	0	179,593	5	20,109,331	5.02
5.03	00570	PATIENT ACCOUNTING	936	0	166,968	8	0	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	3,510	0	141,589	7	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	8,505	0	107,554	2	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	604	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	395	0	237,294	2	0	9.00
10.00	01000	DIETARY	2,415	525	216,769	3	0	10.00
11.00	01100	CAFETERIA	733	0	25,638	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	453	0	2,795	9	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	805	3,021	58,702	2	0	14.00
15.00	01500	PHARMACY	875	14,441	146,297	3	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	984	0	174,154	6	0	16.00
17.00	01700	SOCIAL SERVICE	84	0	6,269	0	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	5,058	7,323	743,911	6	1,351,721	30.00
46.00	04600	OTHER LONG TERM CARE	5,638	1,631	601,647	3	1,024,467	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,325	6,290	122,244	5	554,455	50.00
53.00	05300	ANESTHESIOLOGY	0	832	0	0	42,460	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,971	53,298	322,326	12	5,535,042	54.00
60.00	06000	LABORATORY	1,725	15,417	387,322	6	4,388,082	60.00
65.00	06500	RESPIRATORY THERAPY	99	2,148	2,054	0	85,152	65.00
66.00	06600	PHYSICAL THERAPY	2,546	2,586	825,869	15	2,644,419	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	406	3,546	65,180	2	95,717	68.01
69.00	06900	ELECTROCARDIOLOGY	48	1,803	8,354	0	207,680	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	39,312	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	66,639	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,331,961	73.00
76.00	03480	ONCOLOGY	0	0	0	0	46,383	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,649	6,108	1,005,293	12	1,323,081	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,884	2,641	451,474	7	1,372,760	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,110	142,086	6,186,358	115	20,109,331	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	1,950	0	2,409	8	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	0	47,251	3	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	277,211	207,706	1,637,195	592,060	264,691	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.324837	1.461833	0.262539	4,698.888889	0.013163	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			708	34,894	3,540	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000114	276.936508	0.000176	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	INFORMATION SYSTEMS (# OF COMPUTERS)	ADMITTING (GROSS REVENUES)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description		PATIENT ACCOUNTING (GROSS REVENUES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5.03	5A.04	5.04	6.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	INFORMATION SYSTEMS					5.01
5.02	00591	ADMITTING					5.02
5.03	00570	PATIENT ACCOUNTING	20,109,331				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	-2,699,883	12,639,844		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	622,359	37,647	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	141,935	604	8.00
9.00	00900	HOUSEKEEPING	0	0	340,420	395	9.00
10.00	01000	DIETARY	0	0	390,652	2,415	10.00
11.00	01100	CAFETERIA	0	0	37,391	733	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	48,367	453	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	96,652	805	14.00
15.00	01500	PHARMACY	0	0	255,805	875	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	273,720	984	16.00
17.00	01700	SOCIAL SERVICE	0	0	8,362	84	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	40,800	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,351,721	0	1,287,569	5,058	30.00
46.00	04600	OTHER LONG TERM CARE	1,024,467	0	913,589	5,638	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	554,455	0	311,555	3,325	50.00
53.00	05300	ANESTHESIOLOGY	42,460	0	9,283	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,535,042	0	1,072,784	2,971	54.00
60.00	06000	LABORATORY	4,388,082	0	1,377,717	1,725	60.00
65.00	06500	RESPIRATORY THERAPY	85,152	0	38,708	99	65.00
66.00	06600	PHYSICAL THERAPY	2,644,419	0	1,248,954	2,546	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	95,717	0	108,160	406	68.01
69.00	06900	ELECTROCARDIOLOGY	207,680	0	28,652	48	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	39,312	0	47,367	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	66,639	0	16,118	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,331,961	0	694,173	0	73.00
76.00	03480	ONCOLOGY	46,383	0	1,346	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,323,081	0	1,447,789	3,649	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,372,760	0	1,550,131	2,884	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	43,175	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,109,331	-2,699,883	12,453,533	35,697	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,106	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	0	52,874	1,950	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	0	130,331	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	318,736		2,699,883	755,296	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.015850		0.213601	20.062581	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,218		20,645	46,874	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000359		0.001633	1.245093	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: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description			HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	ADMITTING						5.02
5.03	00570	PATIENT ACCOUNTING						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	36,648					9.00
10.00	01000	DIETARY	2,415	24,993				10.00
11.00	01100	CAFETERIA	733	0	7,911			11.00
13.00	01300	NURSING ADMINISTRATION	453	0	5	72,345		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	805	0	136	0	100,598	14.00
15.00	01500	PHARMACY	875	0	115	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	984	0	361	0	484	16.00
17.00	01700	SOCIAL SERVICE	84	0	0	0	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	5,058	4,704	1,199	22,749	26,048	30.00
46.00	04600	OTHER LONG TERM CARE	5,638	19,700	1,504	28,478	23,421	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,325	0	184	3,437	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,234	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,971	0	479	0	2,328	54.00
60.00	06000	LABORATORY	1,725	0	678	0	5,344	60.00
65.00	06500	RESPIRATORY THERAPY	99	0	3	64	1,752	65.00
66.00	06600	PHYSICAL THERAPY	2,546	0	1,223	0	2,212	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	406	0	93	1,774	2,030	68.01
69.00	06900	ELECTROCARDIOLOGY	48	0	14	296	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	14,185	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,649	0	1,106	0	6,641	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,884	0	807	15,469	14,426	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,698	24,404	7,907	72,267	100,105	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	1,950	0	4	78	173	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	589	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	0	0	0	320	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	421,059	550,294	68,506	73,034	143,874	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.489276	22.017925	8.659588	1.009524	1.430187	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,732	18,373	4,955	5,596	10,590	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.101834	0.735126	0.626343	0.077352	0.105270	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: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		15.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	INFORMATION SYSTEMS				5.01
5.02	00591	ADMITTING				5.02
5.03	00570	PATIENT ACCOUNTING				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY	654,130			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,980		16.00
17.00	01700	SOCIAL SERVICE	0	0	100	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	820	130	90	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	10	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	77	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	531	238	0	54.00
60.00	06000	LABORATORY	227	349	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	29	0	65.00
66.00	06600	PHYSICAL THERAPY	1,535	154	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	16	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	650,420	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	197	695	0	88.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	400	225	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	654,130	1,913	100	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	38	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	29	0	194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	339,049	367,052	12,798	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.518321	185.379798	127.980000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	28,285	8,971	576	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.043241	4.530808	5.760000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-2

Date/Time Prepared:
9/28/2021 12:57 pm

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0 1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0 2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0 3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0 4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0 5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0 6.00
7.00		ADULTS AND PEDIATRICS		1	30.00	-85,312 7.00
8.00		OTHER OUTPATIENT SERVICES		1	93.00	85,312 8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/28/2021 12:57 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,883,794		1,883,794	0	0	30.00
46.00	04600	OTHER LONG TERM CARE	1,918,166		1,918,166	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	504,059		504,059	0	0	50.00
53.00	05300	ANESTHESIOLOGY	62,546		62,546	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,452,762		1,452,762	0	0	54.00
60.00	06000	LABORATORY	1,804,756		1,804,756	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	58,078	0	58,078	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,651,270	0	1,651,270	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	152,538	0	152,538	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	36,706		36,706	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,485		57,485	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,848		39,848	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,179,575		1,179,575	0	0	73.00
76.00	03480	ONCOLOGY	1,889		1,889	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,020,872		2,020,872	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,063,109		2,063,109	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	152,138		152,138	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	137,709		137,709	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
200.00		Subtotal (see instructions)	15,177,300	0	15,177,300	0	0	200.00
201.00		Less Observation Beds	152,138		152,138		0	201.00
202.00		Total (see instructions)	15,025,162	0	15,025,162	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/28/2021 12:57 pm

			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	635,602		635,602		
46.00	04600	OTHER LONG TERM CARE	1,024,467		1,024,467		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	554,455	554,455	0.909107	0.000000
53.00	05300	ANESTHESIOLOGY	0	42,460	42,460	1.473057	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	140,058	5,394,984	5,535,042	0.262466	0.000000
60.00	06000	LABORATORY	203,615	4,184,467	4,388,082	0.411286	0.000000
65.00	06500	RESPIRATORY THERAPY	49,310	35,842	85,152	0.682051	0.000000
66.00	06600	PHYSICAL THERAPY	434,380	2,210,039	2,644,419	0.624436	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000
68.01	06801	CARDIAC REHAB	0	95,717	95,717	1.593635	0.000000
69.00	06900	ELECTROCARDIOLOGY	2,852	204,828	207,680	0.176743	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,158	25,154	39,312	1.462276	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	66,639	66,639	0.597968	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	267,505	1,064,456	1,331,961	0.885593	0.000000
76.00	03480	ONCOLOGY	0	46,383	46,383	0.040726	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,323,081	1,323,081		
90.00	09000	CLINIC	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	6,640	1,366,120	1,372,760	1.502891	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	138,607	138,607	1.097621	0.000000
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	14,706	562,806	577,512	0.238452	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		
200.00		Subtotal (see instructions)	2,793,293	17,316,038	20,109,331		
201.00		Less Observation Beds					
202.00		Total (see instructions)	2,793,293	17,316,038	20,109,331		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
46.00	04600	OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
68.01	06801	CARDIAC REHAB	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03480	ONCOLOGY	0.000000		76.00
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	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/28/2021 12:57 pm

				Title XIX	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	1,883,794		1,883,794	0	1,883,794	30.00
46.00	04600	OTHER LONG TERM CARE	1,918,166		1,918,166	0	1,918,166	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	504,059		504,059	0	504,059	50.00
53.00	05300	ANESTHESIOLOGY	62,546		62,546	0	62,546	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,452,762		1,452,762	0	1,452,762	54.00
60.00	06000	LABORATORY	1,804,756		1,804,756	0	1,804,756	60.00
65.00	06500	RESPIRATORY THERAPY	58,078	0	58,078	0	58,078	65.00
66.00	06600	PHYSICAL THERAPY	1,651,270	0	1,651,270	0	1,651,270	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	152,538	0	152,538	0	152,538	68.01
69.00	06900	ELECTROCARDIOLOGY	36,706		36,706	0	36,706	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,485		57,485	0	57,485	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,848		39,848	0	39,848	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,179,575		1,179,575	0	1,179,575	73.00
76.00	03480	ONCOLOGY	1,889		1,889	0	1,889	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,020,872		2,020,872	0	2,020,872	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,063,109		2,063,109	0	2,063,109	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	152,138		152,138	0	152,138	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	137,709		137,709	0	137,709	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0	0	0	115.00
200.00		Subtotal (see instructions)	15,177,300	0	15,177,300	0	15,177,300	200.00
201.00		Less Observation Beds	152,138		152,138		152,138	201.00
202.00		Total (see instructions)	15,025,162	0	15,025,162	0	15,025,162	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/28/2021 12:57 pm

			Title XIX		Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	635,602		635,602			30.00
46.00	04600	OTHER LONG TERM CARE	1,024,467		1,024,467			46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	554,455	554,455	0.909107	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	42,460	42,460	1.473057	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	140,058	5,394,984	5,535,042	0.262466	0.000000	54.00
60.00	06000	LABORATORY	203,615	4,184,467	4,388,082	0.411286	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	49,310	35,842	85,152	0.682051	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	434,380	2,210,039	2,644,419	0.624436	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	95,717	95,717	1.593635	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	2,852	204,828	207,680	0.176743	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,158	25,154	39,312	1.462276	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	66,639	66,639	0.597968	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	267,505	1,064,456	1,331,961	0.885593	0.000000	73.00
76.00	03480	ONCOLOGY	0	46,383	46,383	0.040726	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,323,081	1,323,081	1.527399	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	6,640	1,366,120	1,372,760	1.502891	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	138,607	138,607	1.097621	0.000000	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	14,706	562,806	577,512	0.238452	0.000000	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
200.00		Subtotal (see instructions)	2,793,293	17,316,038	20,109,331			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,793,293	17,316,038	20,109,331			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
46.00	04600	OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
68.01	06801	CARDIAC REHAB	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03480	ONCOLOGY	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		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	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part II
Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	34,353	554,455	0.061958	0	0	50.00
53.00	05300 ANESTHESIOLOGY	1,383	42,460	0.032572	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	107,574	5,535,042	0.019435	43,959	854	54.00
60.00	06000 LABORATORY	42,928	4,388,082	0.009783	61,297	600	60.00
65.00	06500 RESPIRATORY THERAPY	4,231	85,152	0.049688	7,920	394	65.00
66.00	06600 PHYSICAL THERAPY	30,505	2,644,419	0.011536	16,312	188	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
68.01	06801 CARDIAC REHAB	9,163	95,717	0.095730	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	3,149	207,680	0.015163	1,030	16	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	98	39,312	0.002493	2,240	6	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,555	66,639	0.023335	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	29,971	1,331,961	0.022501	43,419	977	73.00
76.00	03480 ONCOLOGY	33	46,383	0.000711	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	44,350	1,323,081	0.033520	0	0	88.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	32,748	1,372,760	0.023856	1,738	41	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,822	138,607	0.034789	0	0	92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	71	577,512	0.000123	7,704	1	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50 through 199)	346,934	18,449,262		185,619	3,077	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1308		Period: From 05/01/2020 To 04/30/2021		Worksheet D Part IV Date/Time Prepared: 9/28/2021 12:57 pm	
			Title XVIII		Hospital		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	49,515	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
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	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	49,515	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet D
Part IV
Date/Time Prepared:
9/28/2021 12:57 pm

				Title XVIII		Hospital	Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	554,455	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	49,515	0	42,460	1.166156	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,535,042	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	4,388,082	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	85,152	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,644,419	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	0	0	95,717	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	207,680	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	39,312	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	66,639	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,331,961	0.000000	73.00
76.00	03480	ONCOLOGY	0	0	0	46,383	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,323,081	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	1,372,760	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	138,607	0.000000	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	577,512	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	49,515	0	18,449,262		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part IV
Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description		Title XVIII			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	43,959	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	61,297	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	7,920	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	16,312	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,030	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,240	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	43,419	0	0	0	73.00
76.00	03480	ONCOLOGY	0.000000	0	0	0	0	76.00
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	1,738	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	7,704	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Total (lines 50 through 199)		185,619	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part V
Date/Time Prepared:
9/28/2021 12:57 pm

			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	0.909107	0	314,677	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	1.473057	0	25,144	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.262466	0	2,104,413	0	0	54.00	
60.00	06000	LABORATORY	0.411286	0	1,751,235	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.682051	0	11,730	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.624436	0	737,214	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
68.01	06801	CARDIAC REHAB	1.593635	0	60,335	0	0	68.01	
69.00	06900	ELECTROCARDIOLOGY	0.176743	0	105,117	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.462276	0	20,719	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.597968	0	39,256	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.885593	0	706,074	5,634	0	73.00	
76.00	03480	ONCOLOGY	0.040726	0	38,702	0	0	76.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00	
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
91.00	09100	EMERGENCY	1.502891	0	459,815	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.097621	0	94,672	0	0	92.00	
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.238452	0	339,092	23,450	0	93.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00	
200.00		Subtotal (see instructions)		0	6,808,195	29,084	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	6,808,195	29,084	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part V
Date/Time Prepared:
9/28/2021 12:57 pm

			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	286,075	0		50.00
53.00	05300	ANESTHESIOLOGY	37,039	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	552,337	0		54.00
60.00	06000	LABORATORY	720,258	0		60.00
65.00	06500	RESPIRATORY THERAPY	8,000	0		65.00
66.00	06600	PHYSICAL THERAPY	460,343	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	96,152	0		68.01
69.00	06900	ELECTROCARDIOLOGY	18,579	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,297	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,474	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	625,294	4,989		73.00
76.00	03480	ONCOLOGY	1,576	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	691,052	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	103,914	0		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	80,857	5,592		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	3,735,247	10,581		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,735,247	10,581		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1308

Period:

From 05/01/2020

To 04/30/2021

Worksheet D

Part IV

Date/Time Prepared:

9/28/2021 12:57 pm

Cost Center Description			Title XVIII		Swing Beds - SNF		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	49,515	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
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	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	49,515	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1308
Component CCN: 14-Z308

Period:
From 05/01/2020
To 04/30/2021

Worksheet D
Part IV
Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description			Title XVIII		Swing Beds - SNF	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	554,455	0.000000
53.00	05300	ANESTHESIOLOGY	0	49,515	0	42,460	1.166156
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,535,042	0.000000
60.00	06000	LABORATORY	0	0	0	4,388,082	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	85,152	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	2,644,419	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000
68.01	06801	CARDIAC REHAB	0	0	0	95,717	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	207,680	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	39,312	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	66,639	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,331,961	0.000000
76.00	03480	ONCOLOGY	0	0	0	46,383	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,323,081	0.000000
90.00	09000	CLINIC	0	0	0	0	0.000000
91.00	09100	EMERGENCY	0	0	0	1,372,760	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	138,607	0.000000
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	577,512	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000
200.00		Total (lines 50 through 199)	0	49,515	0	18,449,262	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1308

Period:

Worksheet D

Component CCN: 14-Z308

From 05/01/2020
To 04/30/2021Part IV
Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description		Title XVIII		Swing Beds - SNF		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	60,630	0	0	54.00
60.00	06000	LABORATORY	0.000000	96,333	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	23,245	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	304,654	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0.000000	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	618	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	6,304	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	136,915	0	0	73.00
76.00	03480	ONCOLOGY	0.000000	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	6,950	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	98.00
200.00		Total (lines 50 through 199)		635,649	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1308

Period:

Worksheet D

Component CCN: 14-Z308

From 05/01/2020
To 04/30/2021Part V
Date/Time Prepared:
9/28/2021 12:57 pm

			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	0.909107	0	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	1.473057	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.262466	0	0	0	0	54.00	
60.00	06000	LABORATORY	0.411286	0	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.682051	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.624436	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
68.01	06801	CARDIAC REHAB	1.593635	0	0	0	0	68.01	
69.00	06900	ELECTROCARDIOLOGY	0.176743	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.462276	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.597968	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.885593	0	0	0	0	73.00	
76.00	03480	ONCOLOGY	0.040726	0	0	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC						88.00	
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
91.00	09100	EMERGENCY	1.502891	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.097621	0	0	0	0	92.00	
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.238452	0	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00	
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: 14-1308

Period:

Worksheet D

Component CCN: 14-Z308

From 05/01/2020
To 04/30/2021Part V
Date/Time Prepared:
9/28/2021 12:57 pm

				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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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
76.00	03480	ONCOLOGY	0	0		76.00
	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	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS		0		98.00
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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1308	Period: From 05/01/2020 To 04/30/2021	Worksheet D-1 Date/Time Prepared: 9/28/2021 12:57 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,731	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			332	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)			212	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			783	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)			334	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			211	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)			71	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			155	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)			625	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)			274	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			164.40	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			169.34	20.00
21.00	Total general inpatient routine service cost (see instructions)			1,883,794	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)			34,688	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)			12,023	25.00
26.00	Total swing-bed cost (see instructions)			1,462,877	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			420,917	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)			420,917	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)			1,267.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			196,514	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)			196,514	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet D-1

Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description		Title XVIII			Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)							42.00
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT							43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
	Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					98,695		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					295,209		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)					792,394		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					347,385		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,139,779		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)						120	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,267.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						152,138	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet D-1

Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	59,712	1,883,794	0.031698	152,138	4,822	90.00
91.00	Nursing School cost	0	1,883,794	0.000000	152,138	0	91.00
92.00	Allied health cost	0	1,883,794	0.000000	152,138	0	92.00
93.00	All other Medical Education	0	1,883,794	0.000000	152,138	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1308	Period: From 05/01/2020 To 04/30/2021	Worksheet D-3 Date/Time Prepared: 9/28/2021 12:57 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		158,800		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.909107	0	0	50.00
53.00	05300 ANESTHESIOLOGY	1.473057	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.262466	43,959	11,538	54.00
60.00	06000 LABORATORY	0.411286	61,297	25,211	60.00
65.00	06500 RESPIRATORY THERAPY	0.682051	7,920	5,402	65.00
66.00	06600 PHYSICAL THERAPY	0.624436	16,312	10,186	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
68.01	06801 CARDIAC REHAB	1.593635	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	0.176743	1,030	182	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.462276	2,240	3,275	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.597968	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.885593	43,419	38,452	73.00
76.00	03480 ONCOLOGY	0.040726	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	1.502891	1,738	2,612	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.097621	0	0	92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.238452	7,704	1,837	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		185,619	98,695	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		185,619		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1308 Component CCN: 14-Z308	Period: From 05/01/2020 To 04/30/2021	Worksheet D-3 Date/Time Prepared: 9/28/2021 12:57 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.909107	0	0	50.00
53.00	05300 ANESTHESIOLOGY	1.473057	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.262466	60,630	15,913	54.00
60.00	06000 LABORATORY	0.411286	96,333	39,620	60.00
65.00	06500 RESPIRATORY THERAPY	0.682051	23,245	15,854	65.00
66.00	06600 PHYSICAL THERAPY	0.624436	304,654	190,237	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
68.01	06801 CARDIAC REHAB	1.593635	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	0.176743	618	109	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.462276	6,304	9,218	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.597968	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.885593	136,915	121,251	73.00
76.00	03480 ONCOLOGY	0.040726	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	1.502891	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.097621	0	0	92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.238452	6,950	1,657	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		635,649	393,859	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		635,649		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1308	Period: From 05/01/2020 To 04/30/2021	Worksheet E Part B Date/Time Prepared: 9/28/2021 12:57 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,745,828	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)		3,745,828	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		3,783,286	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)		20,693	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,003,927	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)		2,758,666	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)		2,758,666	30.00
31.00	Primary payer payments		1,266	31.00
32.00	Subtotal (line 30 minus line 31)		2,757,400	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)		66,660	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		43,329	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		47,287	36.00
37.00	Subtotal (see instructions)		2,800,729	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,800,729	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		2,192,871	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)		607,858	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: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet E-1
Part I
Date/Time Prepared:
9/28/2021 12:57 pm

		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		350,438		2,227,895	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	04/21/2021	69,149	04/21/2021	35,024	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)		-69,149		-35,024	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)		281,289		2,192,871	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		607,858	6.01
6.02	SETTLEMENT TO PROGRAM		16,123		0	6.02
7.00	Total Medicare program liability (see instructions)		265,166		2,800,729	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: 14-1308

Period:

Worksheet E-1

Component CCN: 14-Z308

From 05/01/2020
To 04/30/2021Part I
Date/Time Prepared:
9/28/2021 12:57 pm

		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		1,650,297		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	12/23/2020	39,583		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	04/21/2021	304,731		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)		-265,148		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)		1,385,149		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		133,155		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,518,304		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: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet E-1
Part II
Date/Time Prepared:
9/28/2021 12:57 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1308

Period:

Worksheet E-2

Component CCN: 14-Z308

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 12:57 pm

		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)		1,151,177	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)		397,798	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		899	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)		1,548,975	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,548,975	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)		1,548,975	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		30,671	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,518,304	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)		1,518,304	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		1,385,149	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)		133,155	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: 14-1308	Period: From 05/01/2020 To 04/30/2021	Worksheet E-3 Part V Date/Time Prepared: 9/28/2021 12:57 pm
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		295,209	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)		295,209	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		298,161	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)		298,161	19.00
20.00	Deductibles (exclude professional component)		40,591	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		257,570	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		257,570	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		11,686	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		7,596	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		10,877	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		265,166	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		265,166	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		281,289	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)		-16,123	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: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet G

Date/Time Prepared:
9/28/2021 12:57 pm

		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	5,732,464	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,802,757	0	0	0	4.00
5.00	Other receivable	111,491	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-245,000	0	0	0	6.00
7.00	Inventory	480,299	0	0	0	7.00
8.00	Prepaid expenses	240,307	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,122,318	0	0	0	11.00
FIXED ASSETS						
12.00	Land	62,855	0	0	0	12.00
13.00	Land improvements	419,030	0	0	0	13.00
14.00	Accumulated depreciation	-404,403	0	0	0	14.00
15.00	Buildings	9,733,074	0	0	0	15.00
16.00	Accumulated depreciation	-8,450,698	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	5,633,375	0	0	0	23.00
24.00	Accumulated depreciation	-5,180,525	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	927,041	0	0	0	27.00
28.00	Accumulated depreciation	-927,041	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)	1,812,708	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	753,586	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	753,586	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,688,612	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	433,450	0	0	0	37.00
38.00	Salaries, wages, and fees payable	632,525	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	256,690	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	2,291,647	0	0	0	42.00
43.00	Due to other funds	1,700,830	0	0	0	43.00
44.00	Other current liabilities	22,517	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,337,659	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	284,532	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	284,532	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,622,191	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	5,066,421	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	5,066,421	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,688,612	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet G-1

Date/Time Prepared:
9/28/2021 12:57 pm

		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		2,576,053		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,490,368				2.00
3.00	Total (sum of line 1 and line 2)		5,066,421		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		5,066,421		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,066,421		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
9/28/2021 12:57 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	256,652		256,652	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	378,950		378,950	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	1,024,467		1,024,467	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,660,069		1,660,069	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)	1,660,069		1,660,069	17.00
18.00	Ancillary services	1,118,518	16,455,987	17,574,505	18.00
19.00	Outpatient services	0	577,512	577,512	19.00
20.00	RURAL HEALTH CLINIC	0	1,864,703	1,864,703	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.)	0	0	0	25.00
26.00	HOSPICE				26.00
27.00	MILL STREET CLINIC	0	54,072	54,072	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,778,587	18,952,274	21,730,861	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		14,086,730		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)		14,086,730		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1308

Period:
From 05/01/2020
To 04/30/2021

Worksheet G-3

Date/Time Prepared:
9/28/2021 12:57 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	21,730,861	1.00
2.00	Less contractual allowances and discounts on patients' accounts	8,920,321	2.00
3.00	Net patient revenues (line 1 minus line 2)	12,810,540	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,086,730	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,276,190	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	90,919	6.00
7.00	Income from investments	23,880	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	2,461	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	11,482	22.00
23.00	Governmental appropriations	428,631	23.00
24.00	GRANT INCOME	123,387	24.00
24.01	MEDICARE AND MEDICAID INCENTIVE REV	0	24.01
24.02	GAIN ON DISPOSAL OF FIXED ASSETS	0	24.02
24.03	OTHER MISCELLANEOUS INCOME	20,783	24.03
24.04	340B	476,862	24.04
24.50	COVID-19 PHE PRF	2,588,153	24.50
25.00	Total other income (sum of lines 6-24)	3,766,558	25.00
26.00	Total (line 5 plus line 25)	2,490,368	26.00
27.00	OTHER EXPENSES	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,490,368	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1308

Period:

Worksheet M-1

Component CCN: 14-3472

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 12:57 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	415,500	0	415,500	0	415,500
2.00	Physician Assistant	282,135	0	282,135	0	282,135
3.00	Nurse Practitioner	0	0	0	0	0
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	299,780	0	299,780	0	299,780
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	997,415	0	997,415	0	997,415
11.00	Physician Services Under Agreement	0	120,000	120,000	0	120,000
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	83,435	83,435	0	83,435
14.00	Subtotal (sum of lines 11 through 13)	0	203,435	203,435	0	203,435
15.00	Medical Supplies	0	9,531	9,531	0	9,531
16.00	Transportation (Health Care Staff)	0	401	401	0	401
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	47,349	47,349	-47,349	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	57,281	57,281	-47,349	9,932
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	997,415	260,716	1,258,131	-47,349	1,210,782
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	7,878	0	7,878	0	7,878
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	7,878	0	7,878	0	7,878
FACILITY OVERHEAD						
29.00	Facility Costs	0	1,645	1,645	0	1,645
30.00	Administrative Costs	0	10,695	10,695	0	10,695
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	12,340	12,340	0	12,340
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,005,293	273,056	1,278,349	-47,349	1,231,000

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1308

Period:

Worksheet M-1

Component CCN: 14-3472

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 12:57 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-46,398	369,102	1.00
2.00	Physician Assistant	0	282,135	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	299,780	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	-46,398	951,017	10.00
11.00	Physician Services Under Agreement	-120,000	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	-880	82,555	13.00
14.00	Subtotal (sum of lines 11 through 13)	-120,880	82,555	14.00
15.00	Medical Supplies	-1,848	7,683	15.00
16.00	Transportation (Health Care Staff)	-305	96	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	-2,153	7,779	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-169,431	1,041,351	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	7,878	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	7,878	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	-838	807	29.00
30.00	Administrative Costs	0	10,695	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-838	11,502	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-170,269	1,060,731	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1308

Period:

Worksheet M-2

Component CCN: 14-3472

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 12:57 pm

		RHC I		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	1.22	3,168	3,150	3,843
2.00	Physician Assistant	0.00	0	1,575	0
3.00	Nurse Practitioner	2.09	4,407	1,575	3,292
4.00	Subtotal (sum of lines 1 through 3)	3.31	7,575	7,135	7,575
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.31	7,575		7,575
9.00	Physician Services Under Agreements		0		0
					1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES					
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				1,041,351
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				7,878
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,049,229
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.992492
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				11,502
15.00	Parent provider overhead allocated to facility (see instructions)				960,141
16.00	Total overhead (sum of lines 14 and 15)				971,643
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				971,643
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				964,348
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				2,005,699

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1308 Component CCN: 14-3472	Period: From 05/01/2020 To 04/30/2021	Worksheet M-3 Date/Time Prepared: 9/28/2021 12:57 pm	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,005,699	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			30,807	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,974,892	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			7,575	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)			7,575	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			260.71	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	260.71	260.71	260.71	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,129	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	555,052	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	555,052		16.00
16.01	Total program charges (see instructions)(from contractor's records)		386,858		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		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.)		405,393		16.04
16.05	Total program cost (see instructions)	0	405,393		16.05
17.00	Primary payer amounts		170		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		48,311		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		66,032		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		405,223		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		405,223		22.00
23.00	Allowable bad debts (see instructions)		5,830		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		3,790		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		5,830		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)		409,013		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		311,109		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)		97,904		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 PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1308 Component CCN: 14-3472	Period: From 05/01/2020 To 04/30/2021	Worksheet M-4 Date/Time Prepared: 9/28/2021 12:57 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		951,017	951,017	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000228	0.003176	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		217	3,020	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		8,895	3,863	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		9,112	6,883	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,041,351	1,041,351	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		964,348	964,348	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.008750	0.006610	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		8,438	6,374	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		17,550	13,257	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		52	725	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		337.50	18.29	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	0	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			30,807	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			0	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1308 Component CCN: 14-3472	Period: From 05/01/2020 To 04/30/2021	Worksheet M-5 Date/Time Prepared: 9/28/2021 12:57 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		302,756	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01		12/23/2020	36,946	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		04/21/2021	28,593	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)		8,353	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		311,109	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		97,904	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		409,013	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00