

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1310	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 2/24/2022 1:52 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 2/24/2022	Time: 1:52 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 BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MENDOTA COMMUNITY HOSPITAL (14-1310) for the cost reporting period beginning 10/01/2020 and ending 09/30/2021 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.

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

Cost Center Description		Title V	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	-390,479	-323,580	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	-338,010	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		206,272		0	10.00
200.00	Total	0	-728,489	-117,308	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: 14-1310		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/24/2022 1:52 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1401 EAST 12TH ST			PO Box:				1.00	
2.00	City: MENDOTA			State: IL		Zip Code: 61342-9216		County: LA SALLE 2.00	
		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		MENDOTA COMMUNITY HOSPITAL	141310	99914	1	01/15/2001	N	O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		MENDOTA COMMUNITY SWING BED- SNF	14Z310	99914		01/25/2001	N	O
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC		MENDOTA COMMUNITY HOSPITAL - RHC	148535	99914		02/11/2015	N	O
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)						10/01/2020	09/30/2021	20.00
21.00	Type of Control (see instructions)						1		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/24/2022 1:52 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1310		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/24/2022 1:52 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
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
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	
		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	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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			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
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		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.	N		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.	N		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.	N		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1310		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/24/2022 1:52 pm	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00	
				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	
				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		
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	
<u>Miscellaneous Cost Reporting Information</u>							
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				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	5,950	16,561	509		118.01	
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N			120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
<u>Transplant Center Information</u>							
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1310		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/24/2022 1:52 pm	
		1.00	2.00				
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		149006		140.00	
		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: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS		Contractor's Number: 00131		141.00	
142.00	Street: 800 N.E. GLEN OAK AVENUE	PO Box:				142.00	
143.00	City: PEORIA	State: IL		Zip Code: 61603		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						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	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1310	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/24/2022 1:52 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1310		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part II Date/Time Prepared: 2/24/2022 1:52 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/14/2021	Y	12/14/2021		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part II
Date/Time Prepared:
2/24/2022 1:52 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		Y		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		Y		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA	RACHELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544	PRACHELL@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part II
Date/Time Prepared:
2/24/2022 1:52 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.	MANAGING DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/24/2022 1:52 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					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	21	7,665	35,098.29	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)		21	7,665	35,098.29	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	374.47	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	35,472.76	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/24/2022 1:52 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)	930	4	1,474		1.00
2.00	HMO and other (see instructions)	199	101			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	1,021	0	1,142		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	96		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,951	4	2,712		7.00
8.00	INTENSIVE CARE UNIT	7	0	12		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)	1,958	4	2,724	0.00	124.82
15.00	CAH visits	0	0	0		14.00
16.00	SUBPROVIDER - IPF					15.00
17.00	SUBPROVIDER - IRF					16.00
18.00	SUBPROVIDER					17.00
19.00	SKILLED NURSING FACILITY					18.00
20.00	NURSING FACILITY					19.00
21.00	OTHER LONG TERM CARE					20.00
22.00	HOME HEALTH AGENCY					21.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					22.00
24.00	HOSPICE					23.00
24.10	HOSPICE (non-distinct part)			0		24.00
25.00	CMHC - CMHC					24.10
26.00	RHC (CONSOLIDATED)	6,457	2,486	15,028	0.00	32.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	156.86
28.00	Observation Bed Days		52	364		27.00
29.00	Ambulance Trips	0				28.00
30.00	Employee discount days (see instruction)			0		29.00
31.00	Employee discount days - IRF			0		30.00
32.00	Labor & delivery days (see instructions)	0	0	0		31.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.00
33.00	LTCH non-covered days	0				32.01
33.01	LTCH site neutral days and discharges	0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/24/2022 1:52 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	266	1	398	1.00
2.00 HMO and other (see instructions)			44	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	266	1	398	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		MENDOTA COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1310 Component CCN: 14-8535		Period: From 10/01/2020 To 09/30/2021 Worksheet S-8 Date/Time Prepared: 2/24/2022 1:52 pm	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	1405 E. 12TH ST.		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MENDOTA IL 61342		2.00	
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0		3.00	
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0 10.00	
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		2.00	
11.00	Facility hours of operations (1)	CLINIC		11.00	
		08:00		17:00	
		08:00			
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y		2 13.00	
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number	MENDOTA COMMUNITY HOSPITAL - RHC		148535 14.00	
14.01		OSF MEDICAL GROUP WASHINGTON STREET		148567 14.01	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County		4.00	
2.00	City, State, ZIP Code, County	LASALLE COUNTY		2.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1310 Component CCN: 14-8535		Period: From 10/01/2020 To 09/30/2021	Worksheet S-8 Date/Time Prepared: 2/24/2022 1:52 pm
					RHC I	Cost
		Tuesday	Wednesday		Thursday	
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1310	Period: From 10/01/2020 To 09/30/2021	Worksheet S-10 Date/Time Prepared: 2/24/2022 1:52 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)			0.345535 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	2,080,463		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	12,027,170		6.00
7.00	Medicaid cost (line 1 times line 6)	4,155,808		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)	2,075,345		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)	2,075,345		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,563,564	367,574	1,931,138 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	540,266	367,574	907,840 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	540,266	367,574	907,840 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,254,129		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	247,009		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	380,014		27.01
28.00	Non-Medicare bad debt expense (see instructions)	874,115		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	435,042		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,342,882		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,418,227		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/24/2022 1:52 pm

	Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (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		219,858	219,858	96,200	316,058	1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS		0	0	256	256	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		522,119	522,119	-60,846	461,273	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	286,803	383,980	670,783	3,003,155	3,673,938	4.00
5.01	01140	BUSINESS OFFICE	0	15,448	15,448	0	15,448	5.01
5.02	00550	DATA PROCESSING	0	25,759	25,759	1,161,079	1,186,838	5.02
5.03	00570	ADMITTING	0	0	0	0	0	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	97,483	83,083	180,566	80,676	261,242	5.04
5.05	00590	OTHER A&G	625,868	6,124,707	6,750,575	-2,096,889	4,653,686	5.05
7.00	00700	OPERATION OF PLANT	280,977	1,425,125	1,706,102	-515,927	1,190,175	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	66,926	66,926	0	66,926	8.00
9.00	00900	HOUSEKEEPING	366,793	177,384	544,177	-97,455	446,722	9.00
10.00	01000	DIETARY	251,648	200,918	452,566	-306,902	145,664	10.00
11.00	01100	CAFETERIA	0	0	0	237,641	237,641	11.00
13.00	01300	NURSING ADMINISTRATION	172,925	44,018	216,943	24,528	241,471	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,135	19,107	52,242	-16,802	35,440	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	267,427	267,427	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,641,246	566,058	2,207,304	-242,260	1,965,044	30.00
31.00	03100	INTENSIVE CARE UNIT	9,961	23,771	33,732	-2,690	31,042	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	353,636	494,436	848,072	-274,794	573,278	50.00
51.00	05100	RECOVERY ROOM	194,640	82,260	276,900	-60,714	216,186	51.00
53.00	05300	ANESTHESIOLOGY	358,341	65,428	423,769	598	424,367	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	394,854	144,361	539,215	401,771	940,986	54.00
54.01	05401	ULTRASOUND	6,367	283,704	290,071	-816	289,255	54.01
54.02	05402	MAMMOGRAPHY	57,651	14,394	72,045	-11,510	60,535	54.02
56.00	05600	RADIOISOTOPE	3,184	220,944	224,128	-40,748	183,380	56.00
57.00	05700	CT SCAN	175,292	94,496	269,788	-51,443	218,345	57.00
58.00	05800	MRI	58,579	26,093	84,672	-16,282	68,390	58.00
60.00	06000	LABORATORY	594,729	934,903	1,529,632	-119,594	1,410,038	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	57,849	57,849	0	57,849	63.00
64.00	06400	INTRAVENOUS THERAPY	281,758	105,195	386,953	-49,967	336,986	64.00
65.00	06500	RESPIRATORY THERAPY	403,106	148,942	552,048	-100,668	451,380	65.00
65.01	06501	SLEEP LAB	34,611	11,754	46,365	-5,693	40,672	65.01
66.00	06600	PHYSICAL THERAPY	489,579	141,208	630,787	-101,227	529,560	66.00
67.00	06700	OCCUPATIONAL THERAPY	84,350	28,324	112,674	-21,984	90,690	67.00
68.00	06800	SPEECH PATHOLOGY	34,679	10,353	45,032	-6,783	38,249	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	5,082	2,777	7,859	-2,153	5,706	69.01
69.02	06902	CARDIOLOGY	0	2,263	2,263	0	2,263	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	-29,206	-29,206	175,597	146,391	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	172,129	3,342,988	3,515,117	46,947	3,562,064	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	143,188	-4,763	138,425	-3,535	134,890	76.00
76.97	07697	CARDIAC REHABILITATION	63,827	27,336	91,163	-21,818	69,345	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,767,447	1,895,235	4,662,682	-1,030,478	3,632,204	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,026,994	2,529,351	3,556,345	-235,897	3,320,448	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,470,862	20,528,886	31,999,748	0	31,999,748	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,633	22,633	0	22,633	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-412	-412	0	-412	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	173,378	173,378	0	173,378	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	11,470,862	20,724,485	32,195,347	0	32,195,347	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/24/2022 1:52 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	26,555	342,613	1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	256	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	799,297	1,260,570	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-97,091	3,576,847	4.00
5.01	01140	BUSINESS OFFICE	-6,501	8,947	5.01
5.02	00550	DATA PROCESSING	0	1,186,838	5.02
5.03	00570	ADMITTING	0	0	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	796,952	1,058,194	5.04
5.05	00590	OTHER A&G	-1,975,606	2,678,080	5.05
7.00	00700	OPERATION OF PLANT	-5,325	1,184,850	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	66,926	8.00
9.00	00900	HOUSEKEEPING	0	446,722	9.00
10.00	01000	DIETARY	0	145,664	10.00
11.00	01100	CAFETERIA	-74,061	163,580	11.00
13.00	01300	NURSING ADMINISTRATION	323,306	564,777	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,240	33,200	16.00
17.00	01700	SOCIAL SERVICE	-84,260	183,167	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-180,623	1,784,421	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31,042	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	573,278	50.00
51.00	05100	RECOVERY ROOM	0	216,186	51.00
53.00	05300	ANESTHESIOLOGY	-344,994	79,373	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-28,001	912,985	54.00
54.01	05401	ULTRASOUND	0	289,255	54.01
54.02	05402	MAMMOGRAPHY	0	60,535	54.02
56.00	05600	RADIOISOTOPE	0	183,380	56.00
57.00	05700	CT SCAN	0	218,345	57.00
58.00	05800	MRI	0	68,390	58.00
60.00	06000	LABORATORY	-1,749	1,408,289	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	57,849	63.00
64.00	06400	INTRAVENOUS THERAPY	-165	336,821	64.00
65.00	06500	RESPIRATORY THERAPY	0	451,380	65.00
65.01	06501	SLEEP LAB	0	40,672	65.01
66.00	06600	PHYSICAL THERAPY	0	529,560	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	90,690	67.00
68.00	06800	SPEECH PATHOLOGY	0	38,249	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0	5,706	69.01
69.02	06902	CARDIOLOGY	0	2,263	69.02
69.03	06903	PULMONARY REHAB	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	146,391	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,159,917	2,402,147	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	134,890	76.00
76.97	07697	CARDIAC REHABILITATION	-3,375	65,970	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-251,436	3,380,768	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-1,301,312	2,019,136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,570,546	28,429,202	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,633	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	691	279	192.00
194.00	07950	OTHER NRCC	0	0	194.00
194.01	07951	MARKETING	0	0	194.01
194.02	07952	FOUNDATION	0	173,378	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,569,855	28,625,492	200.00

RECLASSIFICATIONS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
2/24/2022 1:52 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
B - TO RECLASS COPIER LEASE EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	581	1.00
2.00		0.00	0	0	2.00
	0		0	581	
C - TO RECLASS BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,075,121	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
	0		0	3,075,121	
D - TO RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	158,740	78,901	1.00
	0		158,740	78,901	
E - TO RECLASS VACATION SALARIES					
1.00	PURCHASING RECEIVING AND STORES	5.04	369	0	1.00
2.00	OTHER A&G	5.05	2,367	0	2.00
3.00	OPERATION OF PLANT	7.00	1,063	0	3.00
4.00	HOUSEKEEPING	9.00	1,387	0	4.00
5.00	DIETARY	10.00	952	0	5.00
6.00	NURSING ADMINISTRATION	13.00	654	0	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	125	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	6,208	0	8.00
9.00	INTENSIVE CARE UNIT	31.00	38	0	9.00
10.00	OPERATING ROOM	50.00	1,338	0	10.00
11.00	RECOVERY ROOM	51.00	736	0	11.00
12.00	ANESTHESIOLOGY	53.00	1,355	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	1,494	0	13.00
14.00	ULTRASOUND	54.01	24	0	14.00
15.00	MAMMOGRAPHY	54.02	218	0	15.00
16.00	RADIOISOTOPE	56.00	12	0	16.00
17.00	CT SCAN	57.00	663	0	17.00
18.00	MRI	58.00	222	0	18.00
19.00	LABORATORY	60.00	2,249	0	19.00
20.00	INTRAVENOUS THERAPY	64.00	1,066	0	20.00
21.00	RESPIRATORY THERAPY	65.00	1,525	0	21.00
22.00	SLEEP LAB	65.01	342	0	22.00
23.00	PHYSICAL THERAPY	66.00	1,852	0	23.00
24.00	OCCUPATIONAL THERAPY	67.00	319	0	24.00
25.00	SPEECH PATHOLOGY	68.00	131	0	25.00
26.00	ECHOCARDIOGRAPHY	69.01	50	0	26.00
27.00	DRUGS CHARGED TO PATIENTS	73.00	651	0	27.00
28.00	CANCER CARE CENTER	76.00	542	0	28.00
29.00	RURAL HEALTH CLINIC	88.00	10,467	0	29.00
30.00	EMERGENCY	91.00	3,884	0	30.00
	TOTALS		42,303	0	

RECLASSIFICATIONS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
2/24/2022 1:52 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	F - RECLASS NON-PHYS BONUS & TEAM AWARDS					
1.00	OTHER A&G	5.05	108,922	0		1.00
2.00	HOUSEKEEPING	9.00	6,975	0		2.00
3.00	DIETARY	10.00	5,625	0		3.00
4.00	NURSING ADMINISTRATION	13.00	750	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	26,901	0		5.00
6.00	OPERATING ROOM	50.00	4,200	0		6.00
7.00	RECOVERY ROOM	51.00	2,250	0		7.00
8.00	ANESTHESIOLOGY	53.00	45,155	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	8,850	0		9.00
10.00	LABORATORY	60.00	8,250	0		10.00
11.00	INTRAVENOUS THERAPY	64.00	15,125	0		11.00
12.00	RESPIRATORY THERAPY	65.00	4,500	0		12.00
13.00	SLEEP LAB	65.01	750	0		13.00
14.00	CARDIAC REHABILITATION	76.97	750	0		14.00
15.00	RURAL HEALTH CLINIC	88.00	31,390	0		15.00
16.00	EMERGENCY	91.00	16,410	0		16.00
	TOTALS		286,803	0		
	G - TO RECLASS PHY CLNC OFF EQPMT DPR					
1.00	CAP REL COSTS-OFFSITE MOBS	1.01	0	256		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	63,382		2.00
	0		0	63,638		
	H - TO RECLASS COVID SALARIES					
1.00	ADULTS & PEDIATRICS	30.00	3,402	0		1.00
2.00	EMERGENCY	91.00	508	0		2.00
3.00	INTRAVENOUS THERAPY	64.00	11,206	0		3.00
4.00	OPERATING ROOM	50.00	4,069	0		4.00
5.00	RECOVERY ROOM	51.00	1,750	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	1,834	0		6.00
	TOTALS		22,769	0		
	I - TO RECLASS AUTO & OTHER PROP INSUR					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,211		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	32,818		2.00
3.00	OTHER A&G	5.05	0	35,861		3.00
	0		0	70,890		
	K - TO RECLASS IMPLANTS AND O2 EXP					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	175,597		1.00
	0		0	175,597		
	L - TO RECLASS DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	46,771		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		0	46,771		
	O - TO RECLASS NURSING ADMIN SALARIES					
1.00	NURSING ADMINISTRATION	13.00	65,974	0		1.00
	0		65,974	0		
	V - RHC PHYSICIAN HOSP COSTS					
1.00	ADULTS & PEDIATRICS	30.00	146,720	0		1.00
	0		146,720	0		
	X - UTILITY EXPENSE					
1.00	OPERATION OF PLANT	7.00	0	55,486		1.00
	0		0	55,486		
	Y - CLINICAL ENGINEERING DEPT					
1.00	LABORATORY	60.00	0	36,687		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	516,719		2.00
	0		0	553,406		
	Z - MINISTRY RECLASS					
1.00	OPERATION OF PLANT	7.00	0	56,894		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	40,144		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	328,030		3.00
4.00	PHYSICAL THERAPY	66.00	0	19,258		4.00
5.00	OCCUPATIONAL THERAPY	67.00	0	3,863		5.00
6.00	SPEECH PATHOLOGY	68.00	0	1,412		6.00
7.00	PURCHASING RECEIVING AND STORES	5.04	0	119,299		7.00
8.00	DATA PROCESSING	5.02	0	1,161,079		8.00
9.00	SOCIAL SERVICE	17.00	0	267,427		9.00
	0		0	1,997,406		
500.00	Grand Total: Increases		723,309	6,117,797		500.00

RECLASSIFICATIONS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet A-6
Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	B - TO RECLASS COPIER LEASE EXPENSE						
1.00	SPEECH PATHOLOGY	68.00	0	130	10		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	451	0		2.00
	0		0	581			
	C - TO RECLASS BENEFITS						
1.00	PURCHASING RECEIVING AND STORES	5.04	0	38,992	0		1.00
2.00	OTHER A&G	5.05	0	157,890	0		2.00
3.00	OPERATION OF PLANT	7.00	0	75,964	0		3.00
4.00	HOUSEKEEPING	9.00	0	105,817	0		4.00
5.00	DIETARY	10.00	0	75,838	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	42,850	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	16,927	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	425,491	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	2,728	0		9.00
10.00	OPERATING ROOM	50.00	0	108,804	0		10.00
11.00	RECOVERY ROOM	51.00	0	65,450	0		11.00
12.00	ANESTHESIOLOGY	53.00	0	45,912	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	127,126	0		13.00
14.00	ULTRASOUND	54.01	0	840	0		14.00
15.00	MAMMOGRAPHY	54.02	0	11,728	0		15.00
16.00	RADIOISOTOPE	56.00	0	421	0		16.00
17.00	CT SCAN	57.00	0	47,908	0		17.00
18.00	MRI	58.00	0	16,504	0		18.00
19.00	LABORATORY	60.00	0	166,780	0		19.00
20.00	INTRAVENOUS THERAPY	64.00	0	76,661	0		20.00
21.00	RESPIRATORY THERAPY	65.00	0	106,693	0		21.00
22.00	SLEEP LAB	65.01	0	6,785	0		22.00
23.00	PHYSICAL THERAPY	66.00	0	122,337	0		23.00
24.00	OCCUPATIONAL THERAPY	67.00	0	26,166	0		24.00
25.00	SPEECH PATHOLOGY	68.00	0	8,196	0		25.00
26.00	ECHOCARDIOGRAPHY	69.01	0	672	0		26.00
27.00	DRUGS CHARGED TO PATIENTS	73.00	0	40,619	0		27.00
28.00	CANCER CARE CENTER	76.00	0	4,077	0		28.00
29.00	CARDIAC REHABILITATION	76.97	0	22,568	0		29.00
30.00	RURAL HEALTH CLINIC	88.00	0	869,678	0		30.00
31.00	EMERGENCY	91.00	0	256,699	0		31.00
	0		0	3,075,121			
	D - TO RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	158,740	78,901	0		1.00
	0		158,740	78,901			
	E - TO RECLASS VACATION SALARIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	42,303	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
	TOTALS		0	42,303			

RECLASSIFICATIONS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
2/24/2022 1:52 pm

	Decreases							2/24/2022 1:32 PM
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	F - RECLASS NON-PHYS BONUS & TEAM AWARDS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	286,803	0	0			1.00
2.00		0.00	0	0	0			2.00
3.00		0.00	0	0	0			3.00
4.00		0.00	0	0	0			4.00
5.00		0.00	0	0	0			5.00
6.00		0.00	0	0	0			6.00
7.00		0.00	0	0	0			7.00
8.00		0.00	0	0	0			8.00
9.00		0.00	0	0	0			9.00
10.00		0.00	0	0	0			10.00
11.00		0.00	0	0	0			11.00
12.00		0.00	0	0	0			12.00
13.00		0.00	0	0	0			13.00
14.00		0.00	0	0	0			14.00
15.00		0.00	0	0	0			15.00
16.00		0.00	0	0	0			16.00
	TOTALS		286,803	0				
	G - TO RECLASS PHY CLNC OFF EQPMT DPR							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	63,638	9			1.00
2.00		0.00	0	0	9			2.00
	0		0	63,638				
	H - TO RECLASS COVID SALARIES							
1.00	OTHER A&G	5.05	22,769	0	0			1.00
2.00		0.00	0	0	0			2.00
3.00		0.00	0	0	0			3.00
4.00		0.00	0	0	0			4.00
5.00		0.00	0	0	0			5.00
6.00		0.00	0	0	0			6.00
	TOTALS		22,769	0				
	I - TO RECLASS AUTO & OTHER PROP INSUR							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	70,890	12			1.00
2.00		0.00	0	0	12			2.00
3.00		0.00	0	0	0			3.00
	0		0	70,890				
	K - TO RECLASS IMPLANTS AND O2 EXP							
1.00	OPERATING ROOM	50.00	0	175,597	0			1.00
	0		0	175,597				
	L - TO RECLASS DRUGS							
1.00	RADIOISOTOPE	56.00	0	40,339	0			1.00
2.00	CT SCAN	57.00	0	4,198	0			2.00
3.00	INTRAVENOUS THERAPY	64.00	0	703	0			3.00
4.00	ECHOCARDIOGRAPHY	69.01	0	1,531	0			4.00
	0		0	46,771				
	O - TO RECLASS NURSING ADMIN SALARIES							
1.00	OTHER A&G	5.05	65,974	0	0			1.00
	0		65,974	0				
	V - RHC PHYSICIAN HOSP COSTS							
1.00	RURAL HEALTH CLINIC	88.00	146,720	0	0			1.00
	0		146,720	0				
	X - UTILITY EXPENSE							
1.00	RURAL HEALTH CLINIC	88.00	0	55,486	0			1.00
	0		0	55,486				
	Y - CLINICAL ENGINEERING DEPT							
1.00	OPERATION OF PLANT	7.00	0	553,406	0			1.00
2.00		0.00	0	0	0			2.00
	0		0	553,406				
	Z - MINISTRY RECLASS							
1.00	OTHER A&G	5.05	0	1,997,406	0			1.00
2.00		0.00	0	0	0			2.00
3.00		0.00	0	0	0			3.00
4.00		0.00	0	0	0			4.00
5.00		0.00	0	0	0			5.00
6.00		0.00	0	0	0			6.00
7.00		0.00	0	0	0			7.00
8.00		0.00	0	0	0			8.00
9.00		0.00	0	0	0			9.00
	0		0	1,997,406				
500.00	Grand Total: Decreases		681,006	6,160,100				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part I
Date/Time Prepared:
2/24/2022 1:52 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	1,927,000	0	0	0	0	1.00
2.00	Land Improvements	2,056,749	0	0	0	0	2.00
3.00	Buildings and Fixtures	16,249,923	12,545	0	12,545	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	13,548,142	356,738	0	356,738	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,781,814	369,283	0	369,283	0	8.00
9.00	Reconciling Items	0	12,545	0	12,545	0	9.00
10.00	Total (line 8 minus line 9)	33,781,814	356,738	0	356,738	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,927,000	0				1.00
2.00	Land Improvements	2,056,749	0				2.00
3.00	Buildings and Fixtures	16,262,468	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	13,904,880	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	34,151,097	0				8.00
9.00	Reconciling Items	12,545	0				9.00
10.00	Total (line 8 minus line 9)	34,138,552	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part II
Date/Time Prepared:
2/24/2022 1:52 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	219,858	0	0	0	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	522,119	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	741,977	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	219,858				1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	522,119				2.00
3.00	Total (sum of lines 1-2)	0	741,977				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part III
Date/Time Prepared:
2/24/2022 1:52 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	20,243,977	0	20,243,977	0.592776	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	2,240	0	2,240	0.000066	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	13,904,880	0	13,904,880	0.407158	0	2.00
3.00	Total (sum of lines 1-2)	34,151,097	0	34,151,097	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	334,005	-24,210	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	256	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,257,778	581	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,592,039	-23,629	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	32,818	0	0	342,613	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	0	256	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,211	0	0	1,260,570	2.00
3.00	Total (sum of lines 1-2)	0	35,029	0	0	1,603,439	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8

Date/Time Prepared:
2/24/2022 1:52 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 #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-OFFSITE MOBS (chapter 2)			0CAP REL COSTS-OFFSITE MOBS	1.01	0	1.01
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		0OTHER A&G	5.05	11	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-24,210	CAP REL COSTS-BLDG & FIXT	1.00	10	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	-1,840,276			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)			0	0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-86,807			0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-73,162	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00	Sale of drugs to other than patients			0	0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,240	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00	Vending machines	B	-899	CAFETERIA	11.00	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		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-OFFSITE MOBS			0CAP REL COSTS-OFFSITE MOBS	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8

Date/Time Prepared:
2/24/2022 1:52 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	
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-35	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-6,501	BUSINESS OFFICE	5.01	0	33.01
33.02	MISCELLANEOUS INCOME	B	-605	OTHER A&G	5.05	0	33.02
33.03	MISCELLANEOUS INCOME	B	-165	INTRAVENOUS THERAPY	64.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-3,375	CARDIAC REHABILITATION	76.97	0	33.04
33.05	340B EXPENSE	B	-1,164,095	DRUGS CHARGED TO PATIENTS	73.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-47,812	RURAL HEALTH CLINIC	88.00	0	33.06
33.07	DONATIONS	A	-9,000	OTHER A&G	5.05	0	33.07
33.08	MOB PROPERTY TAXES	A	-18,488	OTHER A&G	5.05	0	33.08
33.09	MOB PROPERTY TAXES	A	-4,296	RURAL HEALTH CLINIC	88.00	0	33.09
33.10	COMMUNITY HEALTH EXPENSE - SALARY	A	-787	OTHER A&G	5.05	0	33.10
33.11	COMMUNITY HEALTH EXPENSE - OTHER	A	-1,994	OTHER A&G	5.05	0	33.11
33.12	COMMUNITY HEALTH BENEFIT EXPENSE	A	-232	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	LOBBYING EXPENSE	A	-13,398	OTHER A&G	5.05	0	33.13
33.14	CRNA BENEFIT EXPENSE	A	-46,031	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	PROVIDER TAX IDPA EXPENSE	A	-935,446	OTHER A&G	5.05	0	33.15
33.16	NON RHC PHYSICIAN BENEFITS	A	-46,107	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.16
33.17	ASSET RE-LIFING	A	-19,913	CAP REL COSTS-BLDG & FIXT	1.00	9	33.17
33.18	ASSET RE-LIFING	A	766,666	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.18
33.19	PROMPTCARE - OTHER	A	692	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.19
33.20	PROMPTCARE - BENEFITS	A	-4	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	PHYSICIAN PT B BENEFITS	A	-4,682	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.21
33.22	OSFMG CRNA EXPENSE	A	13,347	ANESTHESIOLOGY	53.00	0	33.22
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,569,855				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: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-1

Date/Time Prepared:
2/24/2022 1:52 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	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL BLDG HO BLDG CAPITA	79,250	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	327,098	294,467	2.00
3.00	5.05	OTHER A&G	HO POOLED - ADMIN & GENERAL	2,226,987	3,222,875	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY ALLOCATION	328,030	328,030	3.01
3.02	7.00	OPERATION OF PLANT	MINISTRY ALLOCATION	56,932	56,932	3.02
3.03	66.00	PHYSICAL THERAPY	MINISTRY ALLOCATION	19,258	19,258	3.03
3.04	67.00	OCCUPATIONAL THERAPY	MINISTRY ALLOCATION	3,863	3,863	3.04
3.05	68.00	SPEECH PATHOLOGY	MINISTRY ALLOCATION	1,412	1,412	3.05
3.06	73.00	DRUGS CHARGED TO PATIENTS	MINISTRY ALLOCATION	124,802	124,802	3.06
3.07	54.00	RADIOLOGY-DIAGNOSTIC	MINISTRY ALLOCATION	178	178	3.07
3.08	60.00	LABORATORY	MINISTRY ALLOCATION	13	13	3.08
3.09	13.00	NURSING ADMINISTRATION	HO FUNCTIONAL - NURSING ADMI	323,306	0	3.09
3.10	17.00	SOCIAL SERVICE	HO FUNCTIONAL - SOCIAL SERVI	183,167	267,427	3.10
3.11	5.04	PURCHASING RECEIVING AND STO	HO FUNCTIONAL - ADMIN & GEN	1,755,272	958,320	3.11
4.00	73.00	DRUGS CHARGED TO PATIENTS	HO FUNCTIONAL - PHARMACY	4,178	0	4.00
4.01	5.05	OTHER A&G	RELATED PARTY SFI CVO	48,473	48,473	4.01
4.02	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY SFI EETS EQUIP	5,788	9,072	4.02
4.03	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY SFI BIOMED	201	315	4.03
4.04	7.00	OPERATION OF PLANT	SFI HEALTHCARE TECHNOLOGY SV	106,497	111,822	4.04
4.05	54.00	RADIOLOGY-DIAGNOSTIC	SFI HEALTHCARE TECHNOLOGY SV	492,067	516,670	4.05
4.06	60.00	LABORATORY	SFI HEALTHCARE TECHNOLOGY SV	34,971	36,720	4.06
4.07	88.00	RURAL HEALTH CLINIC		0	199,328	4.07
4.08	192.00	PHYSICIANS' PRIVATE OFFICES		0	1	4.08
4.09	1.00	CAP REL COSTS-BLDG & FIXT		0	8,572	4.09
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,121,743	6,208,550	5.00

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

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

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

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

6.00	B	0.00	OSF 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: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-1

Date/Time Prepared:
2/24/2022 1:52 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	79,250	9		1.00
2.00	32,631	9		2.00
3.00	-995,888	0		3.00
3.01	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
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	323,306	0		3.09
3.10	-84,260	0		3.10
3.11	796,952	0		3.11
4.00	4,178	0		4.00
4.01	0	0		4.01
4.02	-3,284	0		4.02
4.03	-114	0		4.03
4.04	-5,325	0		4.04
4.05	-24,603	0		4.05
4.06	-1,749	0		4.06
4.07	-199,328	0		4.07
4.08	-1	0		4.08
4.09	-8,572	9		4.09
5.00	-86,807			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	HOME OFFICE		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: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-2

Date/Time Prepared:
2/24/2022 1:52 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	5.05	OTHER A&G	241,666	0	241,666	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	180,623	180,623	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	358,341	358,341	0	0	0	3.00
4.00	60.00	LABORATORY	16,620	0	16,620	0	0	4.00
5.00	91.00	EMERGENCY	2,118,365	1,301,312	817,053	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			2,915,615	1,840,276	1,075,339		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	5.05	OTHER A&G	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	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	5.05	OTHER A&G	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	180,623		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	358,341		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	91.00	EMERGENCY	0	0	0	1,301,312		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	1,840,276		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 1:52 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	342,613	342,613			1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	256	0	256		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,260,570		1,260,570		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,576,847	483	0	3,579,108	4.00
5.01	01140	BUSINESS OFFICE	8,947	4,559	0	16,773	5.01
5.02	00550	DATA PROCESSING	1,186,838	5,323	0	19,585	5.02
5.03	00570	ADMITTING	0	2,811	0	10,341	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	1,058,194	1,248	0	4,590	5.04
5.05	00590	OTHER A&G	2,678,080	66,725	0	245,499	5.05
7.00	00700	OPERATION OF PLANT	1,184,850	15,366	0	56,535	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	66,926	1,625	0	5,978	8.00
9.00	00900	HOUSEKEEPING	446,722	3,750	0	13,796	9.00
10.00	01000	DIETARY	145,664	9,326	0	34,315	10.00
11.00	01100	CAFETERIA	163,580	3,681	0	13,544	11.00
13.00	01300	NURSING ADMINISTRATION	564,777	1,217	0	4,477	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,200	3,040	0	11,186	16.00
17.00	01700	SOCIAL SERVICE	183,167	1,025	0	3,771	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,784,421	52,363	0	192,658	30.00
31.00	03100	INTENSIVE CARE UNIT	31,042	7,931	0	29,182	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	573,278	14,982	0	55,123	50.00
51.00	05100	RECOVERY ROOM	216,186	16,809	0	61,844	51.00
53.00	05300	ANESTHESIOLOGY	79,373	442	0	1,627	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	912,985	11,486	0	42,259	54.00
54.01	05401	ULTRASOUND	289,255	720	0	2,648	54.01
54.02	05402	MAMMOGRAPHY	60,535	500	0	1,841	54.02
56.00	05600	RADIOISOTOPE	183,380	2,355	0	8,664	56.00
57.00	05700	CT SCAN	218,345	1,587	0	5,839	57.00
58.00	05800	MRI	68,390	3,554	0	13,078	58.00
60.00	06000	LABORATORY	1,408,289	6,142	0	22,599	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	57,849	363	0	1,337	63.00
64.00	06400	INTRAVENOUS THERAPY	336,821	15,397	0	56,649	64.00
65.00	06500	RESPIRATORY THERAPY	451,380	4,781	0	17,592	65.00
65.01	06501	SLEEP LAB	40,672	819	0	3,014	65.01
66.00	06600	PHYSICAL THERAPY	529,560	7,177	0	26,407	66.00
67.00	06700	OCCUPATIONAL THERAPY	90,690	936	0	3,443	67.00
68.00	06800	SPEECH PATHOLOGY	38,249	346	0	1,274	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	5,706	401	0	1,475	69.01
69.02	06902	CARDIOLOGY	2,263	350	0	1,286	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	146,391	9,587	0	35,273	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,402,147	2,711	0	9,975	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	134,890	747	0	2,749	76.00
76.97	07697	CARDIAC REHABILITATION	65,970	1,820	0	6,696	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,380,768	28,761	0	105,819	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,019,136	16,960	0	62,399	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				341,751	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,429,202	330,206	0	1,214,918	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	22,633	829	0	3,052	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	279	11,174	256	41,112	192.00
194.00	07950	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	0	202	0	744	194.01
194.02	07952	FOUNDATION	173,378	202	0	744	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	28,625,492	342,613	256	1,260,570	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			Subtotal	BUSINESS OFFICE	DATA PROCESSING	Subtotal	ADMITTING	
			4A	5.01	5.02	5A.02	5.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE	30,279	30,279				5.01
5.02	00550	DATA PROCESSING	1,211,746	1,292	1,213,038			5.02
5.03	00570	ADMITTING	13,152	14	0	13,166	13,166	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	1,095,948	1,168	0	1,097,116	607	5.04
5.05	00590	OTHER A&G	3,201,535	3,413	49,158	3,254,106	1,788	5.05
7.00	00700	OPERATION OF PLANT	1,348,742	1,438	4,337	1,354,517	749	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	74,529	79	0	74,608	41	8.00
9.00	00900	HOUSEKEEPING	586,629	625	37,591	624,845	346	9.00
10.00	01000	DIETARY	221,753	236	106,990	328,979	182	10.00
11.00	01100	CAFETERIA	232,580	248	0	232,828	129	11.00
13.00	01300	NURSING ADMINISTRATION	648,849	692	76,628	726,169	402	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	58,274	62	0	58,336	32	16.00
17.00	01700	SOCIAL SERVICE	187,963	200	0	188,163	104	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,565,605	2,735	102,653	2,670,993	1,477	30.00
31.00	03100	INTENSIVE CARE UNIT	71,416	76	0	71,492	40	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	761,859	812	5,783	768,454	425	50.00
51.00	05100	RECOVERY ROOM	359,868	384	0	360,252	199	51.00
53.00	05300	ANESTHESIOLOGY	96,612	103	0	96,715	53	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,099,488	1,172	255,910	1,356,570	750	54.00
54.01	05401	ULTRASOUND	294,708	314	0	295,022	163	54.01
54.02	05402	MAMMOGRAPHY	81,751	87	0	81,838	45	54.02
56.00	05600	RADIOISOTOPE	195,441	208	0	195,649	108	56.00
57.00	05700	CT SCAN	283,161	302	0	283,463	157	57.00
58.00	05800	MRI	104,201	111	0	104,312	58	58.00
60.00	06000	LABORATORY	1,634,432	1,742	20,241	1,656,415	916	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	59,549	63	0	59,612	33	63.00
64.00	06400	INTRAVENOUS THERAPY	509,702	543	89,640	599,885	332	64.00
65.00	06500	RESPIRATORY THERAPY	607,196	647	167,714	775,557	429	65.00
65.01	06501	SLEEP LAB	56,150	60	0	56,210	31	65.01
66.00	06600	PHYSICAL THERAPY	723,430	771	56,387	780,588	432	66.00
67.00	06700	OCCUPATIONAL THERAPY	122,685	131	1,446	124,262	69	67.00
68.00	06800	SPEECH PATHOLOGY	51,223	55	0	51,278	28	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	9,256	10	0	9,266	5	69.01
69.02	06902	CARDIOLOGY	3,899	4	0	3,903	2	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	191,251	204	0	191,455	106	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,471,187	2,634	1,446	2,475,267	1,369	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	185,265	197	0	185,462	103	76.00
76.97	07697	CARDIAC REHABILITATION	95,549	102	46,266	141,917	78	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,383,778	4,688	141,690	4,530,156	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,440,246	2,601	49,158	2,492,005	1,378	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,370,887	30,223	1,213,038	28,370,831	13,166	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	26,514	0	0	26,514	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	52,821	56	0	52,877	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	946	0	0	946	0	194.01
194.02	07952	FOUNDATION	174,324	0	0	174,324	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	28,625,492	30,279	1,213,038	28,625,492	13,166	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
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Cost Center Description			PURCHASING RECEIVING AND STORES	Subtotal	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.04	5A.04	5.05	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES	1,097,723					5.04
5.05	00590	OTHER A&G	32,038	3,287,932	3,287,932			5.05
7.00	00700	OPERATION OF PLANT	17,696	1,372,962	178,162	1,551,124		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	74,649	9,687	10,240	94,576	8.00
9.00	00900	HOUSEKEEPING	58,671	683,862	88,741	23,634	0	9.00
10.00	01000	DIETARY	7,145	336,306	43,641	58,783	0	10.00
11.00	01100	CAFETERIA	12,210	245,167	31,814	23,202	0	11.00
13.00	01300	NURSING ADMINISTRATION	172	726,743	94,306	7,669	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,179	59,547	7,727	19,162	0	16.00
17.00	01700	SOCIAL SERVICE	0	188,267	24,430	6,459	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	125,030	2,797,500	363,018	330,034	31,626	30.00
31.00	03100	INTENSIVE CARE UNIT	25,478	97,010	12,589	49,990	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	251,361	1,020,240	132,391	94,428	8,469	50.00
51.00	05100	RECOVERY ROOM	19,675	380,126	49,327	105,943	4,426	51.00
53.00	05300	ANESTHESIOLOGY	30,289	127,057	16,488	2,787	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,279	1,358,599	176,299	72,393	1,623	54.00
54.01	05401	ULTRASOUND	13,247	308,432	40,024	4,537	958	54.01
54.02	05402	MAMMOGRAPHY	916	82,799	10,744	3,154	827	54.02
56.00	05600	RADIOISOTOPE	2,537	198,294	25,732	14,842	714	56.00
57.00	05700	CT SCAN	51,701	335,321	43,513	10,002	7,869	57.00
58.00	05800	MRI	12,136	116,506	15,118	22,403	1,998	58.00
60.00	06000	LABORATORY	84,873	1,742,204	226,077	38,713	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	59,645	7,740	2,290	0	63.00
64.00	06400	INTRAVENOUS THERAPY	33,308	633,525	82,209	97,042	0	64.00
65.00	06500	RESPIRATORY THERAPY	53,231	829,217	107,603	30,137	1,091	65.00
65.01	06501	SLEEP LAB	2,614	58,855	7,637	5,163	0	65.01
66.00	06600	PHYSICAL THERAPY	13,696	794,716	103,126	45,238	6,443	66.00
67.00	06700	OCCUPATIONAL THERAPY	626	124,957	16,215	5,898	1,014	67.00
68.00	06800	SPEECH PATHOLOGY	0	51,306	6,658	2,182	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	196	9,467	1,228	2,528	0	69.01
69.02	06902	CARDIOLOGY	1,417	5,322	691	2,204	0	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	191,561	24,858	60,425	7	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,634	2,510,270	325,745	17,088	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	214	185,779	24,108	4,710	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,226	145,221	18,845	11,471	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	46,440	4,576,596	593,885	181,274	760	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	132,502	2,625,885	340,748	106,894	26,751	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,068,737	28,341,845	3,251,124	1,472,919	94,576	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,986	55,500	7,202	5,228	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	52,877	6,862	70,427	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	946	123	1,275	0	194.01
194.02	07952	FOUNDATION	0	174,324	22,621	1,275	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,097,723	28,625,492	3,287,932	1,551,124	94,576	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 1:52 pm

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	796,237					9.00
10.00	01000	DIETARY	11,018	449,748				10.00
11.00	01100	CAFETERIA	4,300	0	304,483			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	6,099	834,817		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,075	0	2,470	0	89,981	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	214,711	412,131	65,856	175,597	18,934	30.00
31.00	03100	INTENSIVE CARE UNIT	17,199	1,374	328	840	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	49,446	0	13,887	37,019	0	50.00
51.00	05100	RECOVERY ROOM	55,626	14,403	7,485	19,957	15,934	51.00
53.00	05300	ANESTHESIOLOGY	0	0	3,907	10,440	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,221	805	15,399	41,050	1,312	54.00
54.01	05401	ULTRASOUND	0	0	151	391	750	54.01
54.02	05402	MAMMOGRAPHY	0	0	1,991	5,314	562	54.02
56.00	05600	RADIOISOTOPE	8,331	0	76	194	562	56.00
57.00	05700	CT SCAN	5,643	0	6,780	18,106	5,999	57.00
58.00	05800	MRI	12,630	0	1,840	4,884	1,500	58.00
60.00	06000	LABORATORY	32,247	0	27,875	74,315	10,310	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	29,291	0	10,989	29,315	0	64.00
65.00	06500	RESPIRATORY THERAPY	8,062	0	14,820	39,500	0	65.00
65.01	06501	SLEEP LAB	0	0	1,386	3,721	0	65.01
66.00	06600	PHYSICAL THERAPY	30,097	0	13,685	36,492	11,060	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,031	758	2,495	6,661	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,260	3,337	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0	0	126	317	0	69.01
69.02	06902	CARDIOLOGY	0	0	0	0	0	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,419	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,062	0	5,469	14,549	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	0	857	2,271	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	2,722	7,278	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	101,579	0	63,513	215,277	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	114,746	20,277	32,916	87,740	23,058	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	756,734	449,748	304,382	834,565	89,981	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,503	0	0	0	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	101	252	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	796,237	449,748	304,483	834,817	89,981	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 1:52 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01140	BUSINESS OFFICE					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00570	ADMITTING					5.03
5.04	00560	PURCHASING RECEIVING AND STORES					5.04
5.05	00590	OTHER A&G					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	219,156				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	217,760	4,627,167	0	4,627,167	30.00
31.00	03100	INTENSIVE CARE UNIT	0	179,330	0	179,330	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,355,880	0	1,355,880	50.00
51.00	05100	RECOVERY ROOM	0	653,227	0	653,227	51.00
53.00	05300	ANESTHESIOLOGY	0	160,679	0	160,679	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,713,701	0	1,713,701	54.00
54.01	05401	ULTRASOUND	0	355,243	0	355,243	54.01
54.02	05402	MAMMOGRAPHY	0	105,391	0	105,391	54.02
56.00	05600	RADIOISOTOPE	0	248,745	0	248,745	56.00
57.00	05700	CT SCAN	0	433,233	0	433,233	57.00
58.00	05800	MRI	0	176,879	0	176,879	58.00
60.00	06000	LABORATORY	0	2,151,741	0	2,151,741	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	69,675	0	69,675	63.00
64.00	06400	INTRAVENOUS THERAPY	0	882,371	0	882,371	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,030,430	0	1,030,430	65.00
65.01	06501	SLEEP LAB	0	76,762	0	76,762	65.01
66.00	06600	PHYSICAL THERAPY	0	1,040,857	0	1,040,857	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	162,029	0	162,029	67.00
68.00	06800	SPEECH PATHOLOGY	0	64,743	0	64,743	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0	13,666	0	13,666	69.01
69.02	06902	CARDIOLOGY	0	8,217	0	8,217	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	279,270	0	279,270	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,881,183	0	2,881,183	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	217,725	0	217,725	76.00
76.97	07697	CARDIAC REHABILITATION	0	185,537	0	185,537	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	5,732,884	0	5,732,884	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,396	3,380,411	0	3,380,411	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	219,156	28,186,976	0	28,186,976	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	67,930	0	67,930	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	169,669	0	169,669	192.00
194.00	07950	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	0	2,344	0	2,344	194.01
194.02	07952	FOUNDATION	0	198,573	0	198,573	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	219,156	28,625,492	0	28,625,492	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet B
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
				BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP		
			0	1.00	1.01	2.00	2A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	483	0	1,778	2,261	4.00
5.01	01140	BUSINESS OFFICE	0	4,559	0	16,773	21,332	5.01
5.02	00550	DATA PROCESSING	0	5,323	0	19,585	24,908	5.02
5.03	00570	ADMITTING	0	2,811	0	10,341	13,152	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	0	1,248	0	4,590	5,838	5.04
5.05	00590	OTHER A&G	5,400	66,725	0	245,499	317,624	5.05
7.00	00700	OPERATION OF PLANT	0	15,366	0	56,535	71,901	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,625	0	5,978	7,603	8.00
9.00	00900	HOUSEKEEPING	0	3,750	0	13,796	17,546	9.00
10.00	01000	DIETARY	0	9,326	0	34,315	43,641	10.00
11.00	01100	CAFETERIA	0	3,681	0	13,544	17,225	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,217	0	4,477	5,694	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,040	0	11,186	14,226	16.00
17.00	01700	SOCIAL SERVICE	0	1,025	0	3,771	4,796	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	52,363	0	192,658	245,021	30.00
31.00	03100	INTENSIVE CARE UNIT	0	7,931	0	29,182	37,113	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	14,982	0	55,123	70,105	50.00
51.00	05100	RECOVERY ROOM	0	16,809	0	61,844	78,653	51.00
53.00	05300	ANESTHESIOLOGY	0	442	0	1,627	2,069	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,486	0	42,259	53,745	54.00
54.01	05401	ULTRASOUND	0	720	0	2,648	3,368	54.01
54.02	05402	MAMMOGRAPHY	0	500	0	1,841	2,341	54.02
56.00	05600	RADIOISOTOPE	0	2,355	0	8,664	11,019	56.00
57.00	05700	CT SCAN	0	1,587	0	5,839	7,426	57.00
58.00	05800	MRI	0	3,554	0	13,078	16,632	58.00
60.00	06000	LABORATORY	0	6,142	0	22,599	28,741	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	363	0	1,337	1,700	63.00
64.00	06400	INTRAVENOUS THERAPY	0	15,397	0	56,649	72,046	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,781	0	17,592	22,373	65.00
65.01	06501	SLEEP LAB	0	819	0	3,014	3,833	65.01
66.00	06600	PHYSICAL THERAPY	0	7,177	0	26,407	33,584	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	936	0	3,443	4,379	67.00
68.00	06800	SPEECH PATHOLOGY	0	346	0	1,274	1,620	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0	401	0	1,475	1,876	69.01
69.02	06902	CARDIOLOGY	0	350	0	1,286	1,636	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,587	0	35,273	44,860	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,711	0	9,975	12,686	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	747	0	2,749	3,496	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,820	0	6,696	8,516	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	28,761	0	105,819	134,580	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	16,960	0	62,399	79,359	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,400	330,206	0	1,214,918	1,550,524	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	829	0	3,052	3,881	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,174	256	41,112	52,542	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	202	0	744	946	194.01
194.02	07952	FOUNDATION	0	202	0	744	946	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,400	342,613	256	1,260,570	1,608,839	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
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To 09/30/2021Worksheet B
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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE	DATA PROCESSING	ADMITTING	PURCHASING RECEIVING AND STORES	
			4.00	5.01	5.02	5.03	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,261					4.00
5.01	01140	BUSINESS OFFICE	0	21,332				5.01
5.02	00550	DATA PROCESSING	0	910	25,818			5.02
5.03	00570	ADMITTING	0	10	0	13,162		5.03
5.04	00560	PURCHASING RECEIVING AND STORES	20	823	0	606	7,287	5.04
5.05	00590	OTHER A&G	133	2,404	1,046	1,806	213	5.05
7.00	00700	OPERATION OF PLANT	58	1,013	92	748	117	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	56	0	41	0	8.00
9.00	00900	HOUSEKEEPING	77	441	800	345	389	9.00
10.00	01000	DIETARY	20	167	2,277	182	47	10.00
11.00	01100	CAFETERIA	33	175	0	129	81	11.00
13.00	01300	NURSING ADMINISTRATION	50	487	1,631	401	1	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7	44	0	32	8	16.00
17.00	01700	SOCIAL SERVICE	0	141	0	104	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	339	1,927	2,185	1,474	830	30.00
31.00	03100	INTENSIVE CARE UNIT	2	54	0	39	169	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	75	572	123	424	1,673	50.00
51.00	05100	RECOVERY ROOM	41	270	0	199	131	51.00
53.00	05300	ANESTHESIOLOGY	10	73	0	53	201	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	84	826	5,446	749	8	54.00
54.01	05401	ULTRASOUND	1	221	0	163	88	54.01
54.02	05402	MAMMOGRAPHY	12	61	0	45	6	54.02
56.00	05600	RADIOISOTOPE	1	147	0	108	17	56.00
57.00	05700	CT SCAN	36	213	0	156	343	57.00
58.00	05800	MRI	12	78	0	58	81	58.00
60.00	06000	LABORATORY	125	1,227	431	914	563	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	45	0	33	0	63.00
64.00	06400	INTRAVENOUS THERAPY	64	383	1,908	331	221	64.00
65.00	06500	RESPIRATORY THERAPY	84	456	3,570	428	353	65.00
65.01	06501	SLEEP LAB	7	42	0	31	17	65.01
66.00	06600	PHYSICAL THERAPY	101	543	1,200	431	91	66.00
67.00	06700	OCCUPATIONAL THERAPY	17	92	31	69	4	67.00
68.00	06800	SPEECH PATHOLOGY	7	38	0	28	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	1	7	0	5	1	69.01
69.02	06902	CARDIOLOGY	0	3	0	2	9	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	144	0	106	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36	1,856	31	1,366	223	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	30	139	0	102	1	76.00
76.97	07697	CARDIAC REHABILITATION	13	72	985	78	21	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	549	3,299	3,016	0	308	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	216	1,833	1,046	1,376	880	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,261	21,292	25,818	13,162	7,095	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	192	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	40	0	0	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,261	21,332	25,818	13,162	7,287	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2020
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Cost Center Description			OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.05	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G	323,226					5.05
7.00	00700	OPERATION OF PLANT	17,515	91,444				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	952	604	9,256			8.00
9.00	00900	HOUSEKEEPING	8,724	1,393	0	29,715		9.00
10.00	01000	DIETARY	4,290	3,465	0	411	54,500	10.00
11.00	01100	CAFETERIA	3,128	1,368	0	160	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,271	452	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	760	1,130	0	40	0	16.00
17.00	01700	SOCIAL SERVICE	2,402	381	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	35,688	19,456	3,094	8,015	49,942	30.00
31.00	03100	INTENSIVE CARE UNIT	1,238	2,947	0	642	166	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,015	5,567	829	1,845	0	50.00
51.00	05100	RECOVERY ROOM	4,849	6,246	433	2,076	1,745	51.00
53.00	05300	ANESTHESIOLOGY	1,621	164	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,332	4,268	159	1,725	98	54.00
54.01	05401	ULTRASOUND	3,935	267	94	0	0	54.01
54.02	05402	MAMMOGRAPHY	1,056	186	81	0	0	54.02
56.00	05600	RADIOISOTOPE	2,530	875	70	311	0	56.00
57.00	05700	CT SCAN	4,278	590	770	211	0	57.00
58.00	05800	MRI	1,486	1,321	196	471	0	58.00
60.00	06000	LABORATORY	22,225	2,282	0	1,203	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	761	135	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	8,082	5,721	0	1,093	0	64.00
65.00	06500	RESPIRATORY THERAPY	10,578	1,777	107	301	0	65.00
65.01	06501	SLEEP LAB	751	304	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	10,138	2,667	631	1,123	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,594	348	99	150	92	67.00
68.00	06800	SPEECH PATHOLOGY	655	129	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	121	149	0	0	0	69.01
69.02	06902	CARDIOLOGY	68	130	0	0	0	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,444	3,562	1	90	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,024	1,007	0	301	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	2,370	278	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,853	676	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	58,375	10,687	74	3,791	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	33,498	6,302	2,618	4,282	2,457	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	319,607	86,834	9,256	28,241	54,500	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	708	308	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	675	4,152	0	1,474	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	12	75	0	0	0	194.01
194.02	07952	FOUNDATION	2,224	75	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	323,226	91,444	9,256	29,715	54,500	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
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To 09/30/2021Worksheet B
Part II
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			11.00	13.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	22,299					11.00
13.00	01300	NURSING ADMINISTRATION	447	18,434				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	181	0	16,428			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	7,824		17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,822	3,877	3,457	7,774	387,901	30.00
31.00	03100	INTENSIVE CARE UNIT	24	19	0	0	42,413	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,017	817	0	0	96,062	50.00
51.00	05100	RECOVERY ROOM	548	441	2,909	0	98,541	51.00
53.00	05300	ANESTHESIOLOGY	286	231	0	0	4,708	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,128	906	240	0	86,714	54.00
54.01	05401	ULTRASOUND	11	9	137	0	8,294	54.01
54.02	05402	MAMMOGRAPHY	146	117	103	0	4,154	54.02
56.00	05600	RADIOISOTOPE	6	4	103	0	15,191	56.00
57.00	05700	CT SCAN	497	400	1,095	0	16,015	57.00
58.00	05800	MRI	135	108	274	0	20,852	58.00
60.00	06000	LABORATORY	2,041	1,641	1,882	0	63,275	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	2,674	63.00
64.00	06400	INTRAVENOUS THERAPY	805	647	0	0	91,301	64.00
65.00	06500	RESPIRATORY THERAPY	1,085	872	0	0	41,984	65.00
65.01	06501	SLEEP LAB	102	82	0	0	5,169	65.01
66.00	06600	PHYSICAL THERAPY	1,002	806	2,019	0	54,336	66.00
67.00	06700	OCCUPATIONAL THERAPY	183	147	0	0	7,205	67.00
68.00	06800	SPEECH PATHOLOGY	92	74	0	0	2,643	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	9	7	0	0	2,176	69.01
69.02	06902	CARDIOLOGY	0	0	0	0	1,848	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	51,207	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	401	321	0	0	50,252	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	63	50	0	0	6,529	76.00
76.97	07697	CARDIAC REHABILITATION	199	161	0	0	12,574	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,651	4,754	0	0	224,084	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,411	1,937	4,209	50	142,474	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,292	18,428	16,428	7,824	1,540,576	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	5,089	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	58,883	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	1,033	194.01
194.02	07952	FOUNDATION	7	6	0	0	3,258	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	22,299	18,434	16,428	7,824	1,608,839	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/24/2022 1:52 pm

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	01140	BUSINESS OFFICE			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00570	ADMITTING			5.03
5.04	00560	PURCHASING RECEIVING AND STORES			5.04
5.05	00590	OTHER A&G			5.05
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	387,901	30.00
31.00	03100	INTENSIVE CARE UNIT	0	42,413	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	96,062	50.00
51.00	05100	RECOVERY ROOM	0	98,541	51.00
53.00	05300	ANESTHESIOLOGY	0	4,708	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	86,714	54.00
54.01	05401	ULTRASOUND	0	8,294	54.01
54.02	05402	MAMMOGRAPHY	0	4,154	54.02
56.00	05600	RADIOISOTOPE	0	15,191	56.00
57.00	05700	CT SCAN	0	16,015	57.00
58.00	05800	MRI	0	20,852	58.00
60.00	06000	LABORATORY	0	63,275	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	2,674	63.00
64.00	06400	INTRAVENOUS THERAPY	0	91,301	64.00
65.00	06500	RESPIRATORY THERAPY	0	41,984	65.00
65.01	06501	SLEEP LAB	0	5,169	65.01
66.00	06600	PHYSICAL THERAPY	0	54,336	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,205	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,643	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0	2,176	69.01
69.02	06902	CARDIOLOGY	0	1,848	69.02
69.03	06903	PULMONARY REHAB	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	51,207	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	50,252	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	6,529	76.00
76.97	07697	CARDIAC REHABILITATION	0	12,574	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	224,084	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	142,474	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,540,576	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,089	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	58,883	192.00
194.00	07950	OTHER NRCC	0	0	194.00
194.01	07951	MARKETING	0	1,033	194.01
194.02	07952	FOUNDATION	0	3,258	194.02
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,608,839	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 1:52 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		BLDG & FIXT (SQUARE FEET)	OFFSITE MOBS (MOB SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
		1.00	1.01	2.00	4.00	5A.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	99,958				1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	100			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			99,958		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	141	0	141	10,973,414	4.00
5.01	01140	BUSINESS OFFICE	1,330	0	1,330	0	5.01
5.02	00550	DATA PROCESSING	1,553	0	1,553	0	5.02
5.03	00570	ADMITTING	820	0	820	0	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	364	0	364	97,852	5.04
5.05	00590	OTHER A&G	19,467	0	19,467	647,627	5.05
7.00	00700	OPERATION OF PLANT	4,483	0	4,483	282,040	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	474	0	474	0	8.00
9.00	00900	HOUSEKEEPING	1,094	0	1,094	375,155	9.00
10.00	01000	DIETARY	2,721	0	2,721	99,485	10.00
11.00	01100	CAFETERIA	1,074	0	1,074	158,740	11.00
13.00	01300	NURSING ADMINISTRATION	355	0	355	240,303	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	887	0	887	33,260	16.00
17.00	01700	SOCIAL SERVICE	299	0	299	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,277	0	15,277	1,643,854	30.00
31.00	03100	INTENSIVE CARE UNIT	2,314	0	2,314	9,999	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,371	0	4,371	363,243	50.00
51.00	05100	RECOVERY ROOM	4,904	0	4,904	199,376	51.00
53.00	05300	ANESTHESIOLOGY	129	0	129	46,510	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,351	0	3,351	407,032	54.00
54.01	05401	ULTRASOUND	210	0	210	6,391	54.01
54.02	05402	MAMMOGRAPHY	146	0	146	57,869	54.02
56.00	05600	RADIOISOTOPE	687	0	687	3,196	56.00
57.00	05700	CT SCAN	463	0	463	175,955	57.00
58.00	05800	MRI	1,037	0	1,037	58,801	58.00
60.00	06000	LABORATORY	1,792	0	1,792	605,228	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	106	0	106	0	63.00
64.00	06400	INTRAVENOUS THERAPY	4,492	0	4,492	309,155	64.00
65.00	06500	RESPIRATORY THERAPY	1,395	0	1,395	409,131	65.00
65.01	06501	SLEEP LAB	239	0	239	35,703	65.01
66.00	06600	PHYSICAL THERAPY	2,094	0	2,094	491,431	66.00
67.00	06700	OCCUPATIONAL THERAPY	273	0	273	84,669	67.00
68.00	06800	SPEECH PATHOLOGY	101	0	101	34,810	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	117	0	117	5,132	69.01
69.02	06902	CARDIOLOGY	102	0	102	0	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,797	0	2,797	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	791	0	791	172,780	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	218	0	218	143,730	76.00
76.97	07697	CARDIAC REHABILITATION	531	0	531	64,577	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,391	0	8,391	2,662,584	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,948	0	4,948	1,047,796	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	96,338	0	96,338	10,973,414	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	242	0	242	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,260	100	3,260	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	59	0	59	0	194.01
194.02	07952	FOUNDATION	59	0	59	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	342,613	256	1,260,570	3,579,108	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.427570	2.560000	12.610997	0.326162	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				2,261	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 1:52 pm

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	
			BLDG & FIXT (SQUARE FEET)	OFFSITE MOBS (MOB SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
			1.00	1.01	2.00	4.00	5A.01	
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000206		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: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 1:52 pm

Cost Center Description			BUSINESS OFFICE (ACCUM. COST)	DATA PROCESSING (MACHINE HO URS)	Reconciliatio n	ADMITTING (ACCUM. COST)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
			5.01	5.02	5A.03	5.03	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE	28,393,429					5.01
5.02	00550	DATA PROCESSING	1,211,746	839				5.02
5.03	00570	ADMITTING	13,152	0	-13,166	23,827,509		5.03
5.04	00560	PURCHASING RECEIVING AND STORES	1,095,948	0	0	1,097,116	835,126	5.04
5.05	00590	OTHER A&G	3,201,535	34	0	3,254,106	24,374	5.05
7.00	00700	OPERATION OF PLANT	1,348,742	3	0	1,354,517	13,463	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	74,529	0	0	74,608	0	8.00
9.00	00900	HOUSEKEEPING	586,629	26	0	624,845	44,636	9.00
10.00	01000	DIETARY	221,753	74	0	328,979	5,436	10.00
11.00	01100	CAFETERIA	232,580	0	0	232,828	9,289	11.00
13.00	01300	NURSING ADMINISTRATION	648,849	53	0	726,169	131	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	58,274	0	0	58,336	897	16.00
17.00	01700	SOCIAL SERVICE	187,963	0	0	188,163	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,565,605	71	0	2,670,993	95,120	30.00
31.00	03100	INTENSIVE CARE UNIT	71,416	0	0	71,492	19,383	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	761,859	4	0	768,454	191,230	50.00
51.00	05100	RECOVERY ROOM	359,868	0	0	360,252	14,968	51.00
53.00	05300	ANESTHESIOLOGY	96,612	0	0	96,715	23,043	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,099,488	177	0	1,356,570	973	54.00
54.01	05401	ULTRASOUND	294,708	0	0	295,022	10,078	54.01
54.02	05402	MAMMOGRAPHY	81,751	0	0	81,838	697	54.02
56.00	05600	RADIOISOTOPE	195,441	0	0	195,649	1,930	56.00
57.00	05700	CT SCAN	283,161	0	0	283,463	39,333	57.00
58.00	05800	MRI	104,201	0	0	104,312	9,233	58.00
60.00	06000	LABORATORY	1,634,432	14	0	1,656,415	64,570	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	59,549	0	0	59,612	0	63.00
64.00	06400	INTRAVENOUS THERAPY	509,702	62	0	599,885	25,340	64.00
65.00	06500	RESPIRATORY THERAPY	607,196	116	0	775,557	40,497	65.00
65.01	06501	SLEEP LAB	56,150	0	0	56,210	1,989	65.01
66.00	06600	PHYSICAL THERAPY	723,430	39	0	780,588	10,420	66.00
67.00	06700	OCCUPATIONAL THERAPY	122,685	1	0	124,262	476	67.00
68.00	06800	SPEECH PATHOLOGY	51,223	0	0	51,278	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	9,256	0	0	9,266	149	69.01
69.02	06902	CARDIOLOGY	3,899	0	0	3,903	1,078	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	191,251	0	0	191,455	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,471,187	1	0	2,475,267	25,588	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	185,265	0	0	185,462	163	76.00
76.97	07697	CARDIAC REHABILITATION	95,549	32	0	141,917	2,454	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,383,778	98	-4,530,156	0	35,331	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,440,246	34	0	2,492,005	100,805	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,340,608	839	-4,543,322	23,827,509	813,074	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	-26,514	0	22,052	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	52,821	0	-52,877	0	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	-946	0	0	194.01
194.02	07952	FOUNDATION	0	0	-174,324	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	30,279	1,213,038		13,166	1,097,723	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001066	1,445.814064		0.000553	1.314440	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	21,332	25,818		13,162	7,287	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000751	30.772348		0.000552	0.008726	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 1:52 pm

Cost Center Description		BUSINESS OFFICE (ACCUM. COST)	DATA PROCESSING (MACHINE HO URS)	Reconciliatio n	ADMITTING (ACCUM. COST)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
		5.01	5.02	5A.03	5.03	5.04	
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: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 1:52 pm

Cost Center Description		Reconciliation	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5A.05	5.05	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01140	BUSINESS OFFICE					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00570	ADMITTING					5.03
5.04	00560	PURCHASING RECEIVING AND STORES					5.04
5.05	00590	OTHER A&G	-3,287,932	25,337,560			5.05
7.00	00700	OPERATION OF PLANT	0	1,372,962	71,800		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	74,649	474	82,475	8.00
9.00	00900	HOUSEKEEPING	0	683,862	1,094	0	9.00
10.00	01000	DIETARY	0	336,306	2,721	0	10.00
11.00	01100	CAFETERIA	0	245,167	1,074	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	726,743	355	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	59,547	887	0	16.00
17.00	01700	SOCIAL SERVICE	0	188,267	299	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,797,500	15,277	27,581	30.00
31.00	03100	INTENSIVE CARE UNIT	0	97,010	2,314	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,020,240	4,371	7,385	50.00
51.00	05100	RECOVERY ROOM	0	380,126	4,904	3,860	51.00
53.00	05300	ANESTHESIOLOGY	0	127,057	129	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,358,599	3,351	1,415	54.00
54.01	05401	ULTRASOUND	0	308,432	210	835	54.01
54.02	05402	MAMMOGRAPHY	0	82,799	146	721	54.02
56.00	05600	RADIOISOTOPE	0	198,294	687	623	56.00
57.00	05700	CT SCAN	0	335,321	463	6,862	57.00
58.00	05800	MRI	0	116,506	1,037	1,742	58.00
60.00	06000	LABORATORY	0	1,742,204	1,792	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	59,645	106	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	633,525	4,492	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	829,217	1,395	951	65.00
65.01	06501	SLEEP LAB	0	58,855	239	0	65.01
66.00	06600	PHYSICAL THERAPY	0	794,716	2,094	5,619	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	124,957	273	884	67.00
68.00	06800	SPEECH PATHOLOGY	0	51,306	101	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0	9,467	117	0	69.01
69.02	06902	CARDIOLOGY	0	5,322	102	0	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	191,561	2,797	6	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,510,270	791	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	185,779	218	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	145,221	531	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,576,596	8,391	663	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,625,885	4,948	23,328	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,287,932	25,053,913	68,180	82,475	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	55,500	242	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	52,877	3,260	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	0	946	59	0	194.01
194.02	07952	FOUNDATION	0	174,324	59	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		3,287,932	1,551,124	94,576	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.129765	21.603398	1.146723	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		323,226	91,444	9,256	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.012757	1.273593	0.112228	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 1:52 pm

Cost Center Description		Reconciliation	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5A.05	5.05	7.00	8.00	9.00	
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: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 1:52 pm

Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATIO N (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	9,493					10.00
11.00	01100	CAFETERIA	0	12,081				11.00
13.00	01300	NURSING ADMINISTRATION	0	242	258,437			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	98	0	480		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	314	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,699	2,613	54,360	101	312	30.00
31.00	03100	INTENSIVE CARE UNIT	29	13	260	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	551	11,460	0	0	50.00
51.00	05100	RECOVERY ROOM	304	297	6,178	85	0	51.00
53.00	05300	ANESTHESIOLOGY	0	155	3,232	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17	611	12,708	7	0	54.00
54.01	05401	ULTRASOUND	0	6	121	4	0	54.01
54.02	05402	MAMMOGRAPHY	0	79	1,645	3	0	54.02
56.00	05600	RADIOISOTOPE	0	3	60	3	0	56.00
57.00	05700	CT SCAN	0	269	5,605	32	0	57.00
58.00	05800	MRI	0	73	1,512	8	0	58.00
60.00	06000	LABORATORY	0	1,106	23,006	55	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	436	9,075	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	588	12,228	0	0	65.00
65.01	06501	SLEEP LAB	0	55	1,152	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	543	11,297	59	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	16	99	2,062	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	50	1,033	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0	5	98	0	0	69.01
69.02	06902	CARDIOLOGY	0	0	0	0	0	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	217	4,504	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	34	703	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	108	2,253	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	2,520	66,645	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	428	1,306	27,162	123	2	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,493	12,077	258,359	480	314	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	4	78	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	449,748	304,483	834,817	89,981	219,156	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	47.376804	25.203460	3.230253	187.460417	697.949045	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	54,500	22,299	18,434	16,428	7,824	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.741072	1.845791	0.071329	34.225000	24.917197	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 1:52 pm

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATIO N (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		10.00	11.00	13.00	16.00	17.00	
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/24/2022 1:52 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	4,627,167		4,627,167	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	179,330		179,330	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,355,880		1,355,880	0	0	50.00
51.00	05100	RECOVERY ROOM	653,227		653,227	0	0	51.00
53.00	05300	ANESTHESIOLOGY	160,679		160,679	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,713,701		1,713,701	0	0	54.00
54.01	05401	ULTRASOUND	355,243		355,243	0	0	54.01
54.02	05402	MAMMOGRAPHY	105,391		105,391	0	0	54.02
56.00	05600	RADIOISOTOPE	248,745		248,745	0	0	56.00
57.00	05700	CT SCAN	433,233		433,233	0	0	57.00
58.00	05800	MRI	176,879		176,879	0	0	58.00
60.00	06000	LABORATORY	2,151,741		2,151,741	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	69,675		69,675	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	882,371		882,371	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,030,430	0	1,030,430	0	0	65.00
65.01	06501	SLEEP LAB	76,762	0	76,762	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,040,857	0	1,040,857	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	162,029	0	162,029	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	64,743	0	64,743	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	13,666		13,666	0	0	69.01
69.02	06902	CARDIOLOGY	8,217		8,217	0	0	69.02
69.03	06903	PULMONARY REHAB	0		0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	279,270		279,270	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,881,183		2,881,183	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.00	03020	CANCER CARE CENTER	217,725		217,725	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	185,537		185,537	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,732,884		5,732,884	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,380,411		3,380,411	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	563,104		563,104	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	28,750,080	0	28,750,080	0	0	200.00
201.00		Less Observation Beds	563,104		563,104			201.00
202.00		Total (see instructions)	28,186,976	0	28,186,976	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/24/2022 1:52 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	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,704,503		3,704,503		30.00
31.00	03100	INTENSIVE CARE UNIT	38,740		38,740		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	179,018	4,336,987	4,516,005	0.300239	0.000000
51.00	05100	RECOVERY ROOM	2,151	944,390	946,541	0.690120	0.000000
53.00	05300	ANESTHESIOLOGY	105,580	1,828,689	1,934,269	0.083070	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	181,718	2,392,911	2,574,629	0.665611	0.000000
54.01	05401	ULTRASOUND	60,564	1,681,468	1,742,032	0.203924	0.000000
54.02	05402	MAMMOGRAPHY	4,613	1,094,512	1,099,125	0.095886	0.000000
56.00	05600	RADIOISOTOPE	38,881	1,094,425	1,133,306	0.219486	0.000000
57.00	05700	CT SCAN	723,657	10,687,440	11,411,097	0.037966	0.000000
58.00	05800	MRI	94,485	3,031,759	3,126,244	0.056579	0.000000
60.00	06000	LABORATORY	1,390,728	13,453,707	14,844,435	0.144953	0.000000
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	47,148	102,924	150,072	0.464277	0.000000
64.00	06400	INTRAVENOUS THERAPY	4,688	912,648	917,336	0.961884	0.000000
65.00	06500	RESPIRATORY THERAPY	966,885	591,691	1,558,576	0.661136	0.000000
65.01	06501	SLEEP LAB	0	496,737	496,737	0.154532	0.000000
66.00	06600	PHYSICAL THERAPY	231,025	2,915,181	3,146,206	0.330829	0.000000
67.00	06700	OCCUPATIONAL THERAPY	53,115	438,873	491,988	0.329335	0.000000
68.00	06800	SPEECH PATHOLOGY	11,458	99,259	110,717	0.584761	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000
69.01	06901	ECHOCARDIOGRAPHY	150,362	1,265,779	1,416,141	0.009650	0.000000
69.02	06902	CARDIOLOGY	67,138	1,167,908	1,235,046	0.006653	0.000000
69.03	06903	PULMONARY REHAB	0	0	0	0.000000	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,497	702,741	719,238	0.388286	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	2,126,409	8,525,882	10,652,291	0.270475	0.000000
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000
76.00	03020	CANCER CARE CENTER	167	135,882	136,049	1.600343	0.000000
76.97	07697	CARDIAC REHABILITATION	0	280,650	280,650	0.661097	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6,622,992	6,622,992		88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	249,405	5,717,792	5,967,197	0.566499	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	79,289	523,349	602,638	0.934398	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	10,528,224	71,046,576	81,574,800		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	10,528,224	71,046,576	81,574,800		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/24/2022 1:52 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
31.00	03100	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	ULTRASOUND	0.000000			54.01
54.02	05402	MAMMOGRAPHY	0.000000			54.02
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000			63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
65.01	06501	SLEEP LAB	0.000000			65.01
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
69.01	06901	ECHOCARDIOGRAPHY	0.000000			69.01
69.02	06902	CARDIOLOGY	0.000000			69.02
69.03	06903	PULMONARY REHAB	0.000000			69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000			75.00
76.00	03020	CANCER CARE CENTER	0.000000			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
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
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part II
Date/Time Prepared:
2/24/2022 1:52 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)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	96,062	4,516,005	0.021271	53,307	1,134	50.00
51.00	05100 RECOVERY ROOM	98,541	946,541	0.104106	0	0	51.00
53.00	05300 ANESTHESIOLOGY	4,708	1,934,269	0.002434	23,205	56	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	86,714	2,574,629	0.033680	84,090	2,832	54.00
54.01	05401 ULTRASOUND	8,294	1,742,032	0.004761	21,818	104	54.01
54.02	05402 MAMMOGRAPHY	4,154	1,099,125	0.003779	0	0	54.02
56.00	05600 RADIOISOTOPE	15,191	1,133,306	0.013404	32,890	441	56.00
57.00	05700 CT SCAN	16,015	11,411,097	0.001403	177,493	249	57.00
58.00	05800 MRI	20,852	3,126,244	0.006670	29,234	195	58.00
60.00	06000 LABORATORY	63,275	14,844,435	0.004263	536,571	2,287	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	2,674	150,072	0.017818	24,367	434	63.00
64.00	06400 INTRAVENOUS THERAPY	91,301	917,336	0.099528	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	41,984	1,558,576	0.026937	386,683	10,416	65.00
65.01	06501 SLEEP LAB	5,169	496,737	0.010406	0	0	65.01
66.00	06600 PHYSICAL THERAPY	54,336	3,146,206	0.017270	28,412	491	66.00
67.00	06700 OCCUPATIONAL THERAPY	7,205	491,988	0.014645	1,912	28	67.00
68.00	06800 SPEECH PATHOLOGY	2,643	110,717	0.023872	2,896	69	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901 ECHOCARDIOGRAPHY	2,176	1,416,141	0.001537	106,147	163	69.01
69.02	06902 CARDIOLOGY	1,848	1,235,046	0.001496	24,533	37	69.02
69.03	06903 PULMONARY REHAB	0	0	0.000000	0	0	69.03
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	51,207	719,238	0.071196	9,232	657	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	50,252	10,652,291	0.004717	827,205	3,902	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.00	03020 CANCER CARE CENTER	6,529	136,049	0.047990	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	12,574	280,650	0.044803	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	224,084	6,622,992	0.033834	0	0	88.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	142,474	5,967,197	0.023876	30,189	721	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	47,206	602,638	0.078332	108	8	92.00
200.00	Total (lines 50 through 199)	1,157,468	77,831,557		2,400,292	24,224	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/24/2022 1:52 pm

Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
54.01	05401	ULTRASOUND	0	0	0	0	0 54.01
54.02	05402	MAMMOGRAPHY	0	0	0	0	0 54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
65.01	06501	SLEEP LAB	0	0	0	0	0 65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
69.01	06901	ECHOCARDIOGRAPHY	0	0	0	0	0 69.01
69.02	06902	CARDIOLOGY	0	0	0	0	0 69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0 69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
76.00	03020	CANCER CARE CENTER	0	0	0	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
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
200.00		Total (lines 50 through 199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1310		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/24/2022 1:52 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)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	4,516,005	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	946,541	0.000000	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	1,934,269	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	2,574,629	0.000000	54.00
54.01	05401	ULTRASOUND		0	0	0	1,742,032	0.000000	54.01
54.02	05402	MAMMOGRAPHY		0	0	0	1,099,125	0.000000	54.02
56.00	05600	RADIOISOTOPE		0	0	0	1,133,306	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	11,411,097	0.000000	57.00
58.00	05800	MRI		0	0	0	3,126,244	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	14,844,435	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0	0	0	150,072	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	917,336	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	1,558,576	0.000000	65.00
65.01	06501	SLEEP LAB		0	0	0	496,737	0.000000	65.01
66.00	06600	PHYSICAL THERAPY		0	0	0	3,146,206	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	491,988	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	110,717	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0.000000	69.00
69.01	06901	ECHOCARDIOGRAPHY		0	0	0	1,416,141	0.000000	69.01
69.02	06902	CARDIOLOGY		0	0	0	1,235,046	0.000000	69.02
69.03	06903	PULMONARY REHAB		0	0	0	0	0.000000	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	719,238	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	10,652,291	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0.000000	75.00
76.00	03020	CANCER CARE CENTER		0	0	0	136,049	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	280,650	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	6,622,992	0.000000	88.00
90.00	09000	CLINIC		0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	5,967,197	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	602,638	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	77,831,557		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/24/2022 1:52 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	53,307	0	0	0 50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0 51.00
53.00	05300	ANESTHESIOLOGY	0.000000	23,205	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	84,090	0	0	0 54.00
54.01	05401	ULTRASOUND	0.000000	21,818	0	0	0 54.01
54.02	05402	MAMMOGRAPHY	0.000000	0	0	0	0 54.02
56.00	05600	RADIOISOTOPE	0.000000	32,890	0	0	0 56.00
57.00	05700	CT SCAN	0.000000	177,493	0	0	0 57.00
58.00	05800	MRI	0.000000	29,234	0	0	0 58.00
60.00	06000	LABORATORY	0.000000	536,571	0	0	0 60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	24,367	0	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	386,683	0	0	0 65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0 65.01
66.00	06600	PHYSICAL THERAPY	0.000000	28,412	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,912	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,896	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
69.01	06901	ECHOCARDIOGRAPHY	0.000000	106,147	0	0	0 69.01
69.02	06902	CARDIOLOGY	0.000000	24,533	0	0	0 69.02
69.03	06903	PULMONARY REHAB	0.000000	0	0	0	0 69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	9,232	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	827,205	0	0	0 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0 75.00
76.00	03020	CANCER CARE CENTER	0.000000	0	0	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
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	30,189	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	108	0	0	0 92.00
200.00		Total (lines 50 through 199)		2,400,292	0	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/24/2022 1:52 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	0.300239	0	1,460,239	0	0	50.00
51.00	05100	RECOVERY ROOM	0.690120	0	326,612	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.083070	0	559,617	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.665611	0	858,009	0	0	54.00
54.01	05401	ULTRASOUND	0.203924	0	555,898	0	0	54.01
54.02	05402	MAMMOGRAPHY	0.095886	0	235,807	0	0	54.02
56.00	05600	RADIOISOTOPE	0.219486	0	537,785	0	0	56.00
57.00	05700	CT SCAN	0.037966	0	4,422,566	0	0	57.00
58.00	05800	MRI	0.056579	0	948,950	0	0	58.00
60.00	06000	LABORATORY	0.144953	0	5,183,395	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.464277	0	70,348	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.961884	0	485,465	78	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.661136	0	264,670	0	0	65.00
65.01	06501	SLEEP LAB	0.154532	0	189,356	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.330829	0	1,151,848	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.329335	0	123,086	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.584761	0	15,660	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0.009650	0	629,096	0	0	69.01
69.02	06902	CARDIOLOGY	0.006653	0	501,697	0	0	69.02
69.03	06903	PULMONARY REHAB	0.000000	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.388286	0	66,478	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270475	0	4,552,581	499	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	1.600343	0	68,205	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.661097	0	167,386	0	0	76.97
	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	0.566499	0	2,108,021	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.934398	0	290,145	0	0	92.00
200.00		Subtotal (see instructions)		0	25,772,920	577	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	25,772,920	577	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/24/2022 1:52 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	438,421	0		50.00
51.00	05100	RECOVERY ROOM	225,401	0		51.00
53.00	05300	ANESTHESIOLOGY	46,487	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	571,100	0		54.00
54.01	05401	ULTRASOUND	113,361	0		54.01
54.02	05402	MAMMOGRAPHY	22,611	0		54.02
56.00	05600	RADIOISOTOPE	118,036	0		56.00
57.00	05700	CT SCAN	167,907	0		57.00
58.00	05800	MRI	53,691	0		58.00
60.00	06000	LABORATORY	751,349	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	32,661	0		63.00
64.00	06400	INTRAVENOUS THERAPY	466,961	75		64.00
65.00	06500	RESPIRATORY THERAPY	174,983	0		65.00
65.01	06501	SLEEP LAB	29,262	0		65.01
66.00	06600	PHYSICAL THERAPY	381,065	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	40,537	0		67.00
68.00	06800	SPEECH PATHOLOGY	9,157	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	ECHOCARDIOGRAPHY	6,071	0		69.01
69.02	06902	CARDIOLOGY	3,338	0		69.02
69.03	06903	PULMONARY REHAB	0	0		69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,812	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,231,359	135		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03020	CANCER CARE CENTER	109,151	0		76.00
76.97	07697	CARDIAC REHABILITATION	110,658	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	1,194,192	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	271,111	0		92.00
200.00		Subtotal (see instructions)	6,594,682	210		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,594,682	210		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1310	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/24/2022 1:52 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)			3,076	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,838	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,474	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			286	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)			856	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			24	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)			72	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			930	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)			281	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)			740	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			178.59	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			178.59	20.00
21.00	Total general inpatient routine service cost (see instructions)			4,627,167	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			4,286	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)			12,858	25.00
26.00	Total swing-bed cost (see instructions)			1,783,807	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,843,360	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)			2,843,360	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)			1,546.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,438,701	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,438,701	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/24/2022 1:52 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	179,330	12	14,944.17	7	104,609	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)					696,142	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,239,452	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)					434,704	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,144,773	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,579,477	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)					364	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,546.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					563,104	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1310		Period: From 10/01/2020 To 09/30/2021		Worksheet D-1 Date/Time Prepared: 2/24/2022 1:52 pm	
		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	387,901	4,627,167	0.083831	563,104	47,206	90.00
91.00	Nursing Program cost	0	4,627,167	0.000000	563,104	0	91.00
92.00	Allied health cost	0	4,627,167	0.000000	563,104	0	92.00
93.00	All other Medical Education	0	4,627,167	0.000000	563,104	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1310	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/24/2022 1:52 pm
			Title XVIII	Hospital	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,028,286	30.00
31.00	03100	INTENSIVE CARE UNIT		15,198	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.300239	53,307	50.00
51.00	05100	RECOVERY ROOM	0.690120	0	51.00
53.00	05300	ANESTHESIOLOGY	0.083070	23,205	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.665611	84,090	54.00
54.01	05401	ULTRASOUND	0.203924	21,818	54.01
54.02	05402	MAMMOGRAPHY	0.095886	0	54.02
56.00	05600	RADIOISOTOPE	0.219486	32,890	56.00
57.00	05700	CT SCAN	0.037966	177,493	57.00
58.00	05800	MRI	0.056579	29,234	58.00
60.00	06000	LABORATORY	0.144953	536,571	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.464277	24,367	63.00
64.00	06400	INTRAVENOUS THERAPY	0.961884	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.661136	386,683	65.00
65.01	06501	SLEEP LAB	0.154532	0	65.01
66.00	06600	PHYSICAL THERAPY	0.330829	28,412	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.329335	1,912	67.00
68.00	06800	SPEECH PATHOLOGY	0.584761	2,896	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0.009650	106,147	69.01
69.02	06902	CARDIOLOGY	0.006653	24,533	69.02
69.03	06903	PULMONARY REHAB	0.000000	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.388286	9,232	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270475	827,205	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
76.00	03020	CANCER CARE CENTER	1.600343	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.661097	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.566499	30,189	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.934398	108	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,400,292	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)		2,400,292	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1310	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3
			Component CCN: 14-Z310		Date/Time Prepared: 2/24/2022 1:52 pm
			Title XVIII	Swing Beds - SNF	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.300239	0	50.00
51.00	05100	RECOVERY ROOM	0.690120	0	51.00
53.00	05300	ANESTHESIOLOGY	0.083070	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.665611	25,789	54.00
54.01	05401	ULTRASOUND	0.203924	7,395	54.01
54.02	05402	MAMMOGRAPHY	0.095886	0	54.02
56.00	05600	RADIOISOTOPE	0.219486	0	56.00
57.00	05700	CT SCAN	0.037966	19,639	57.00
58.00	05800	MRI	0.056579	30,466	58.00
60.00	06000	LABORATORY	0.144953	249,210	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.464277	7,175	63.00
64.00	06400	INTRAVENOUS THERAPY	0.961884	104	64.00
65.00	06500	RESPIRATORY THERAPY	0.661136	259,878	65.00
65.01	06501	SLEEP LAB	0.154532	0	65.01
66.00	06600	PHYSICAL THERAPY	0.330829	168,861	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.329335	40,862	67.00
68.00	06800	SPEECH PATHOLOGY	0.584761	8,562	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0.009650	13,515	69.01
69.02	06902	CARDIOLOGY	0.006653	5,345	69.02
69.03	06903	PULMONARY REHAB	0.000000	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.388286	2,308	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270475	535,312	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
76.00	03020	CANCER CARE CENTER	1.600343	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.661097	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.566499	8,410	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.934398	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,382,831	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)		1,382,831	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1310	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/24/2022 1:52 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			6,594,892 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	OPPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			6,594,892 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			6,660,841 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)			31,895 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			4,066,800 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)			2,562,146 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)			2,562,146 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			2,562,146 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)			362,008 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			235,305 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			362,382 36.00
37.00	Subtotal (see instructions)			2,797,451 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)			2,797,451 40.00
40.01	Sequestration adjustment (see instructions)			0 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
40.03	Sequestration adjustment-PARHM pass-throughs			0 40.03
41.00	Interim payments			3,121,031 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)			-323,580 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			77,000 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: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part I
Date/Time Prepared:
2/24/2022 1:52 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		2,584,099		3,444,916	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	06/17/2021	137,832	06/17/2021	211,595	3.50
3.51		08/26/2021	53,491	08/26/2021	112,290	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)		-191,323		-323,885	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,392,776		3,121,031	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		390,479		323,580	6.02
7.00	Total Medicare program liability (see instructions)		2,002,297		2,797,451	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: 14-1310

Period:

Worksheet E-1

Component CCN: 14-Z310

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/24/2022 1:52 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		2,440,712		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	06/17/2021	60,901		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)		-60,901		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,379,811		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		338,010		0	6.02
7.00	Total Medicare program liability (see instructions)		2,041,801		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: 14-1310	Period: From 10/01/2020 To 09/30/2021	Worksheet E-1 Part II Date/Time Prepared: 2/24/2022 1:52 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 through 12, and 32.			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8, sum of lines 1, 8 through 12, and 32.			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1310 Component CCN: 14-Z310	Period: From 10/01/2020 To 09/30/2021	Worksheet E-2 Date/Time Prepared: 2/24/2022 1:52 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)	1,595,272	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)	462,031	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	1,021	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)	2,057,303	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,057,303	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)	2,057,303	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	15,502	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	2,041,801	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)	2,041,801	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	2,379,811	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)	-338,010	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
Comparison 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: 14-1310	Period: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part V Date/Time Prepared: 2/24/2022 1:52 pm	
		Title XVIII	Hospital	Cost	
				1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT					
1.00	Inpatient services			2,239,452	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0	2.00
3.00	Organ acquisition			0	3.00
4.00	Subtotal (sum of lines 1 through 3)			2,239,452	4.00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,261,847	6.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
7.00	Routine service charges			0	7.00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9.00
10.00	Total reasonable charges			0	10.00
Customary charges					
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.00
14.00	Total customary charges (see instructions)			0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,261,847	19.00
20.00	Deductibles (exclude professional component)			271,254	20.00
21.00	Excess reasonable cost (from line 16)			0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)			1,990,593	22.00
23.00	Coinsurance			0	23.00
24.00	Subtotal (line 22 minus line 23)			1,990,593	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			18,006	25.00
26.00	Adjusted reimbursable bad debts (see instructions)			11,704	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			18,006	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,002,297	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29.50
29.98	Recovery of accelerated depreciation.			0	29.98
29.99	Demonstration payment adjustment amount before sequestration			0	29.99
30.00	Subtotal (see instructions)			2,002,297	30.00
30.01	Sequestration adjustment (see instructions)			0	30.01
30.02	Demonstration payment adjustment amount after sequestration			0	30.02
30.03	Sequestration adjustment-PARHM				30.03
31.00	Interim payments			2,392,776	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)			-390,479	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			5,743	34.00

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

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet G

Date/Time Prepared:
2/24/2022 1:52 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	79,244	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	11,210,150	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,971,776	0	0	0	6.00
7.00	Inventory	728,975	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	54,629	0	0	0	9.00
10.00	Due from other funds	21,868	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,123,090	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,927,000	0	0	0	12.00
13.00	Land improvements	2,056,749	0	0	0	13.00
14.00	Accumulated depreciation	-1,477,499	0	0	0	14.00
15.00	Buildings	16,249,923	0	0	0	15.00
16.00	Accumulated depreciation	-7,531,701	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	13,904,880	0	0	0	23.00
24.00	Accumulated depreciation	-11,147,095	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	12,545	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,994,802	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	165,007	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	12,854,443	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	13,019,450	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	32,137,342	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	612,537	0	0	0	37.00
38.00	Salaries, wages, and fees payable	330,248	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	7,503,533	0	0	0	43.00
44.00	Other current liabilities	17,628	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,463,946	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	10,832,134	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,832,134	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,296,080	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	12,841,262	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)	12,841,262	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	32,137,342	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet G-1

Date/Time Prepared:
2/24/2022 1:52 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		8,247,857		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,395,267				2.00
3.00	Total (sum of line 1 and line 2)		12,643,124		0		3.00
4.00	OPERATIONS	-1		0		0	4.00
5.00	TEMP RESTRICTED FUNDS	198,144		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)		198,143		0		10.00
11.00	Subtotal (line 3 plus line 10)		12,841,267		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ROUNDING	5		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)		5		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,841,262		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	OPERATIONS		0				4.00
5.00	TEMP RESTRICTED FUNDS		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	ROUNDING		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: 14-1310

Period:
From 10/01/2020
To 09/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
2/24/2022 1:52 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,508,189		2,508,189	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,103,547		1,103,547	5.00
6.00	Swing bed - NF	92,767		92,767	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,704,503		3,704,503	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	38,740		38,740	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)	38,740		38,740	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,743,243		3,743,243	17.00
18.00	Ancillary services	6,451,767	58,186,963	64,638,730	18.00
19.00	Outpatient services	328,694	6,241,141	6,569,835	19.00
20.00	RURAL HEALTH CLINIC	0	6,622,992	6,622,992	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	107,454	3,105,532	3,212,986	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,631,158	74,156,628	84,787,786	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,195,347		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)		32,195,347		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2020
To 09/30/2021

Worksheet G-3

Date/Time Prepared:
2/24/2022 1:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	84,787,786	1.00
2.00	Less contractual allowances and discounts on patients' accounts	51,450,059	2.00
3.00	Net patient revenues (line 1 minus line 2)	33,337,727	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,195,347	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,142,380	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	95,051	6.00
7.00	Income from investments	13,629	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	73,162	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	1,678,609	17.00
18.00	Revenue from sale of medical records and abstracts	2,240	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	605	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	33,357	20.00
21.00	Rental of vending machines	899	21.00
22.00	Rental of hospital space	24,210	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	510,237	24.00
24.50	COVID-19 PHE Funding	1,210,297	24.50
25.00	Total other income (sum of lines 6-24)	3,642,296	25.00
26.00	Total (line 5 plus line 25)	4,784,676	26.00
27.00	EQUITY TRANSFER	389,409	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	389,409	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,395,267	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1310

Period:

Worksheet M-1

Component CCN: 14-8535

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/24/2022 1:52 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,127,181	0	1,127,181	-186,415	940,766
2.00	Physician Assistant	132,561	0	132,561	-8,864	123,697
3.00	Nurse Practitioner	257,649	0	257,649	-16,284	241,365
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	1,041,114	0	1,041,114	-2,641	1,038,473
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)	2,558,505	0	2,558,505	-214,204	2,344,301
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	259,786	259,786	0	259,786
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	22,950	22,950	0	22,950
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	282,736	282,736	0	282,736
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,558,505	282,736	2,841,241	-214,204	2,627,037
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	106,181	106,181
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	106,181	106,181
FACILITY OVERHEAD						
29.00	Facility Costs	0	77,273	77,273	-55,486	21,787
30.00	Administrative Costs	208,942	1,535,226	1,744,168	-866,969	877,199
31.00	Total Facility Overhead (sum of lines 29 and 30)	208,942	1,612,499	1,821,441	-922,455	898,986
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,767,447	1,895,235	4,662,682	-1,030,478	3,632,204

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1310

Period:

Worksheet M-1

Component CCN: 14-8535

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/24/2022 1:52 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	0	940,766	1.00
2.00	Physician Assistant	0	123,697	2.00
3.00	Nurse Practitioner	0	241,365	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	1,038,473	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,344,301	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	259,786	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	22,950	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	282,736	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,627,037	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	106,181	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	106,181	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	21,787	29.00
30.00	Administrative Costs	-251,436	625,763	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-251,436	647,550	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-251,436	3,380,768	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1310

Period:

Worksheet M-2

Component CCN: 14-8535

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/24/2022 1:52 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	2.97	9,522	4,200	12,474	1.00
2.00	Physician Assistant	0.86	1,897	2,100	1,806	2.00
3.00	Nurse Practitioner	1.69	3,609	2,100	3,549	3.00
4.00	Subtotal (sum of lines 1 through 3)	5.52	15,028		17,829	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.52	15,028		17,829	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				2,627,037	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				106,181	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				2,733,218	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.961152	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				647,550	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				2,352,116	15.00
16.00	Total overhead (sum of lines 14 and 15)				2,999,666	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				2,999,666	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				2,883,135	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				5,510,172	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1310 Component CCN: 14-8535	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/24/2022 1:52 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)			5,510,172	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			260,334	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			5,249,838	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			17,829	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)			17,829	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			294.45	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)	86.31	87.52	267.51	8.00
9.00	Rate for Program covered visits (see instructions)	294.45	294.45	267.51	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	1,441	1,543	3,473	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	424,302	454,336	929,062	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	1,807,700		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,607,215		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		51,934		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		58,412		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,295,719		16.04
16.05	Total program cost (see instructions)	0	1,354,131		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		129,639		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		285,128		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,354,131		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		87,159		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,441,290		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		1,441,290		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		1,235,018		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)		206,272		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1310

Period:

Worksheet M-4

Component CCN: 14-8535

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/24/2022 1:52 pm

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,344,301	2,344,301	2,344,301	2,344,301	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001900	0.007804	0.006068	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	4,454	18,295	14,225	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	61,462	25,681	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	65,916	43,976	14,225	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,627,037	2,627,037	2,627,037	2,627,037	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,883,135	2,883,135	2,883,135	2,883,135	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.025091	0.016740	0.005415	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	72,341	48,264	15,612	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	138,257	92,240	29,837	0	10.00
11.00	Total number of injections/infusions (from your records)	404	1,659	1,290	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	342.22	55.60	23.13	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	124	524	531	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			143	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	42,435	29,134	15,590	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		260,334			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		87,159			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1310 Component CCN: 14-8535	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/24/2022 1:52 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		1,235,018	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,235,018		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		206,272		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		1,441,290		7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00