

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1313	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 2/28/2022 9:53 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 2/28/2022	Time: 9:53 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MASON DISTRICT HOSPITAL (14-1313) 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	Doug Kosier	Y	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	Doug Kosier		2
3	Signatory Title	CHIEF EXECUTIVE OFFICER		3
4	Date	(Dated when report is electronica		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	-35,792	-180,005	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	-247,432	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		109,484		0	10.00
10.01 RURAL HEALTH CLINIC II	0		14,853		0	10.01
10.02 RURAL HEALTH CLINIC III	0		8,921		0	10.02
200.00 Total	0	-283,224	-46,747	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: 14-1313		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 9:53 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 615 NORTH PROMENADE STREET			PO Box:				1.00		
2.00	City: HAVANA			State: IL		Zip Code: 62644-0530		County: MASON 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		MASON DISTRICT HOSPITAL	141313	99914	1	07/01/2001	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		MASON DISTRICT HOSPITAL	142313	99914		07/01/2001	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLT									
12.00	Hospital-Based HHA		MASON DISTRICT HHA	147202	99914		01/09/1982	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		HAVANA MEDICAL ASSOCIATES RHC	143457	99914		02/01/2001	O	O	O
15.01	Hospital-Based Health Clinic - RHC II		MASON CITY MEDICAL ASSOCIATES	143462	99914		03/03/2003	O	O	O
15.02	Hospital-Based Health Clinic - RHC III		MANITO MEDICAL ASSOCIATES	148592	99914		04/19/2018	O	O	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)						11			21.00
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
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: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/28/2022 9:53 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	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.							
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: 14-1313		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 9:53 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)					0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00
					0.000000	64.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/28/2022 9:53 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1313	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 9:53 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1313	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 9:53 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
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.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	96,241	0	0 118.01
		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
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1313		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 9:53 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1313	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/28/2022 9:53 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	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	02/03/2021	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		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		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part II
Date/Time Prepared:
2/28/2022 9:53 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		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.	DAVID	MCCLUNG		41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6414942144	DAVID.MCCLUNG@RSMUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1313

Period:
From 10/01/2020
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Date/Time Prepared:
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		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.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 9:53 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	17,856.22	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)		25	9,125	17,856.22	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	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	17,856.22	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	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RHC (CONSOLIDATED)	88.02				0	26.02
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: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 9:53 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	441	11	790			1.00
2.00	HMO and other (see instructions)	117	51				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	537	0	543			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	74			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	978	11	1,407			7.00
8.00	INTENSIVE CARE UNIT	0	0	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)	978	11	1,407	0.00	177.90	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	5,673	0	8,918	0.00	11.62	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	4,646	4,348	15,767	0.00	45.88	26.00
26.01	RURAL HEALTH CLINIC II	213	485	1,192	0.00	3.57	26.01
26.02	RHC (CONSOLIDATED)	285	1,527	3,375	0.00	3.22	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	242.19	27.00
28.00	Observation Bed Days		0	144			28.00
29.00	Ambulance Trips	531					29.00
30.00	Employee discount days (see instruction)			4			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 9:53 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	115	3	211	1.00
2.00 HMO and other (see instructions)			33	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	115	3	211	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	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RHC (CONSOLIDATED)	0.00					26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		MASON DISTRICT HOSPITAL			In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-1313 Component CCN: 14-7202		Period: From 10/01/2020 To 09/30/2021	
				Home Health Agency I		Worksheet S-4 Date/Time Prepared: 2/28/2022 9:53 am	
						PPS	
						1.00	
0.00 County						0.00	
				Title V	Title XVIII	Title XIX	Other
				1.00	2.00	3.00	4.00
						Total	5.00
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	1,337	0	775	0	2,112	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	183.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		1.00	0.00	1.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			1.17	0.00	1.17	5.00
6.00	Direct Nursing Service			8.36	0.00	8.36	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.07	0.00	0.07	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.02	0.00	1.02	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
						CBSA Data	
						1.00	
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					3	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					37900	20.00
20.01						44100	20.01
20.02						99914	20.02
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	2,640	550	43	2	3,235	21.00
22.00	Skilled Nursing Visit Charges	801,219	166,777	13,045	608	981,649	22.00
23.00	Physical Therapy Visits	884	443	7	1	1,335	23.00
24.00	Physical Therapy Visit Charges	295,880	147,995	2,345	335	446,555	24.00
25.00	Occupational Therapy Visits	358	302	3	2	665	25.00
26.00	Occupational Therapy Visit Charges	119,770	100,910	1,005	670	222,355	26.00
27.00	Speech Pathology Visits	23	28	0	0	51	27.00
28.00	Speech Pathology Visit Charges	7,515	9,210	0	0	16,725	28.00
29.00	Medical Social Service Visits	8	3	0	0	11	29.00
30.00	Medical Social Service Visit Charges	2,680	1,005	0	0	3,685	30.00
31.00	Home Health Aide Visits	277	96	3	0	376	31.00
32.00	Home Health Aide Visit Charges	46,396	16,088	504	0	62,988	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,190	1,422	56	5	5,673	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,273,460	441,985	16,899	1,613	1,733,957	35.00
36.00	Total Number of Episodes (standard/non outlier)	509		39	1	549	36.00
37.00	Total Number of Outlier Episodes		70		0	70	37.00
38.00	Total Non-Routine Medical Supply Charges	11,695	3,791	263	0	15,749	38.00

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1313 Component CCN: 14-3457		Period: From 10/01/2020 To 09/30/2021 Worksheet S-8 Date/Time Prepared: 2/28/2022 9:53 am	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	615 N PROMENADE ST		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	HAVANA IL 62644		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		11.00	
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0 13.00	
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			14.00	
		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	MASON		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00
		17:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1313

Period:

Worksheet S-8

Component CCN: 14-3457

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 9:53 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:00	17:00				11.00

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1313 Component CCN: 14-3462		Period: From 10/01/2020 To 09/30/2021 Worksheet S-8 Date/Time Prepared: 2/28/2022 9:53 am	
		RHC II		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	122 EAST ELM STREET		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MASON CITY		IL 62664-0530	2.00
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	08:00		16:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	MASON		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	16:00	08:00	16:00	08:00
		16:00		08:00	16:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1313 Component CCN: 14-3462		Period: From 10/01/2020 To 09/30/2021		Worksheet S-8 Date/Time Prepared: 2/28/2022 9:53 am	
						RHC II		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC	08:00	16:00						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 14-1313
 Component CCN: 14-8592

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

Worksheet S-8

 Date/Time Prepared:
 2/28/2022 9:53 am

		RHC III		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street		1301 S. EAST AVENUE		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		MANITO IL 61546		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		16:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?		Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		Y 1		13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		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		MASON		2.00
		Tuesday	Wednesday		Thursday
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	CLINIC		16:00	08:00	16:00
		08:00		16:00	16:00
		11.00			

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1313

Period:

Worksheet S-8

Component CCN: 14-8592

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 9:53 am

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1313

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

Worksheet S-10

Date/Time Prepared:
2/28/2022 9:53 am

				1.00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.546961	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			372,808	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?			N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			147,195	5.00
6.00	Medicaid charges			6,057,448	6.00
7.00	Medicaid cost (line 1 times line 6)			3,313,188	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)			2,793,185	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP			20,859	9.00
10.00	Stand-alone CHIP charges			53,115	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			29,052	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			8,193	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			3,540,787	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			2,801,378	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)	41,769	31,291	73,060	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	22,846	31,291	54,137	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)	22,846	31,291	54,137	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)			1,467,291	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			177,394	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			272,913	27.01
28.00	Non-Medicare bad debt expense (see instructions)			1,194,378	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			748,797	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			802,934	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			3,604,312	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1313

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

Worksheet A

Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	465,066	465,066	1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING		0	0	41,542	41,542	1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG		0	0	344,938	344,938	1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL		0	0	46,905	46,905	1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,436,165	1,436,165	-733,738	702,427	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,345,448	1,345,448	0	1,345,448	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	871,070	1,139,196	2,010,266	0	2,010,266	5.01
5.02	00591	A&G HOSPITAL ONLY	379,913	239,435	619,348	0	619,348	5.02
6.00	00600	MAINTENANCE & REPAIRS	260,841	294,066	554,907	0	554,907	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	0	238,979	238,979	0	238,979	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	21,339	21,339	0	21,339	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	0	14,897	14,897	0	14,897	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	28,634	18,982	47,616	0	47,616	8.00
9.00	00900	HOUSEKEEPING	302,097	84,878	386,975	0	386,975	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	241,763	228,325	470,088	0	470,088	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	200,562	21,912	222,474	0	222,474	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	96,548	10,294	106,842	0	106,842	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	131,495	85,127	216,622	0	216,622	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	334,076	334,076	0	334,076	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	996,972	592,602	1,589,574	0	1,589,574	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	172,456	72,453	244,909	0	244,909	50.00
53.00	05300	ANESTHESIOLOGY	0	197	197	0	197	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	626,065	397,402	1,023,467	-99,419	924,048	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	71,186	43,182	114,368	3,279	117,647	54.01
56.00	05600	RADIOISOTOPE	0	113,648	113,648	350	113,998	56.00
58.00	05800	MRI	0	135,569	135,569	1,177	136,746	58.00
60.00	06000	LABORATORY	799,612	1,052,696	1,852,308	80,477	1,932,785	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	65,612	65,612	0	65,612	62.00
64.00	06400	INTRAVENOUS THERAPY	0	14,716	14,716	0	14,716	64.00
66.00	06600	PHYSICAL THERAPY	617,562	145,144	762,706	0	762,706	66.00
67.00	06700	OCCUPATIONAL THERAPY	239,704	35,763	275,467	0	275,467	67.00
68.00	06800	SPEECH PATHOLOGY	73,824	8,237	82,061	0	82,061	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	442,925	111,606	554,531	14,136	568,667	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	542,688	542,688	0	542,688	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	327,477	651,421	978,898	0	978,898	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	210,483	135,275	345,758	0	345,758	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	1,337	435	1,772	0	1,772	76.01
76.02	03950	DIABETIC EDUCATION	20,255	7,420	27,675	0	27,675	76.02
76.03	03951	WOUND CARE	0	99,995	99,995	0	99,995	76.03
76.04	03953	ALLERGY 123	0	555	555	0	555	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,028,845	1,291,091	5,319,936	-116,989	5,202,947	88.00
88.01	08801	RURAL HEALTH CLINIC II	327,800	104,581	432,381	0	432,381	88.01
88.02	08802	RURAL HEALTH CLINIC III	632,121	240,783	872,904	0	872,904	88.02
91.00	09100	EMERGENCY	468,527	1,726,740	2,195,267	718,761	2,914,028	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,066,319	119,857	1,186,176	-718,761	467,415	95.00
101.00	10100	HOME HEALTH AGENCY	714,552	107,519	822,071	0	822,071	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		164,713	164,713	-164,713	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,350,945	13,495,019	27,845,964	-116,989	27,728,975	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	12,840	6,957	19,797	116,989	136,786	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	14,363,785	13,501,976	27,865,761	0	27,865,761	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1313

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

Worksheet A

Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-34,683	430,383	1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	41,542	1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	-55,120	289,818	1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL	0	46,905	1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	702,427	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	991,245	2,336,693	4.00
5.01	00500	ADMINISTRATIVE AND GENERAL	-40,527	1,969,739	5.01
5.02	00501	A&G HOSPITAL ONLY	0	619,348	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	554,907	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	6.01
7.00	00700	OPERATION OF PLANT	-538	238,441	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	21,339	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	0	14,897	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	47,616	8.00
9.00	00900	HOUSEKEEPING	0	386,975	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	9.01
10.00	01000	DIETARY	-139,379	330,709	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	222,474	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	106,842	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,952	213,670	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-35,371	298,705	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-349,440	1,240,134	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	244,909	50.00
53.00	05300	ANESTHESIOLOGY	0	197	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,994	922,054	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	117,647	54.01
56.00	05600	RADIOISOTOPE	0	113,998	56.00
58.00	05800	MRI	0	136,746	58.00
60.00	06000	LABORATORY	-9,770	1,923,015	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	65,612	62.00
64.00	06400	INTRAVENOUS THERAPY	0	14,716	64.00
66.00	06600	PHYSICAL THERAPY	0	762,706	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	275,467	67.00
68.00	06800	SPEECH PATHOLOGY	0	82,061	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03160	CARDIOPULMONARY	-30,486	538,181	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	542,688	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-63,237	915,661	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	345,758	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	1,772	76.01
76.02	03950	DIABETIC EDUCATION	0	27,675	76.02
76.03	03951	WOUND CARE	-98,400	1,595	76.03
76.04	03953	ALLERGY 123	0	555	76.04
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	5,202,947	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	432,381	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	872,904	88.02
91.00	09100	EMERGENCY	-192,516	2,721,512	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	467,415	95.00
101.00	10100	HOME HEALTH AGENCY	0	822,071	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-63,168	27,665,807	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	136,786	192.00
194.00	07950	HOSPICE	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-63,168	27,802,593	200.00

RECLASSIFICATIONS

Provider CCN: 14-1313

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

Worksheet A-6

Date/Time Prepared:
2/28/2022 9:53 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	61,089	1.00	
2.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	103,624	2.00	
	0		0	164,713		
	B - EMS SALARY TO ER					
1.00	EMERGENCY	91.00	718,761	0	1.00	
	0		718,761	0		
	C - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	403,977	1.00	
2.00	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	41,542	2.00	
3.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	241,314	3.00	
4.00	NEW CAP REL COSTS - WEST CAMPUS_BUIL	1.03	0	46,905	4.00	
	0		0	733,738		
	D - RHC PHYSICIAN					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	116,989	0	1.00	
	0		116,989	0		
	E - OP REGISTRATION					
1.00	LABORATORY	60.00	63,504	16,973	1.00	
2.00	CARDIOPULMONARY	69.01	11,154	2,982	2.00	
3.00	RADIOLOGY-ULTRASOUND	54.01	2,587	692	3.00	
4.00	RADIOISOTOPE	56.00	276	74	4.00	
5.00	RADIOLOGY-DIAGNOSTIC	54.00	3,717	994	5.00	
6.00	MRI	58.00	929	248	6.00	
	0		82,167	21,963		
500.00	Grand Total: Increases		917,917	920,414	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1313

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

Worksheet A-6

Date/Time Prepared:
2/28/2022 9:53 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	164,713	11	1.00
2.00		0.00	0	0	11	2.00
	0		0	164,713		
B - EMS SALARY TO ER						
1.00	AMBULANCE SERVICES	95.00	718,761	0	0	1.00
	0		718,761	0		
C - DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	733,738	9	1.00
2.00		0.00	0	0	9	2.00
3.00		0.00	0	0	9	3.00
4.00		0.00	0	0	9	4.00
	0		0	733,738		
D - RHC PHYSICIAN						
1.00	RURAL HEALTH CLINIC	88.00	116,989	0	0	1.00
	0		116,989	0		
E - OP REGISTRATION						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	82,167	21,963	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
	0		82,167	21,963		
500.00	Grand Total: Decreases		917,917	920,414		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part I
Date/Time Prepared:
2/28/2022 9:53 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	163,928	0	0	0	0	1.00
2.00	Land Improvements	603,633	0	0	0	0	2.00
3.00	Buildings and Fixtures	18,709,520	243,373	0	243,373	0	3.00
4.00	Building Improvements	25,747	71,250	0	71,250	0	4.00
5.00	Fixed Equipment	3,668,009	239,595	0	239,595	0	5.00
6.00	Movable Equipment	10,633,031	906,957	0	906,957	184,856	6.00
7.00	HIT designated Assets	1,231,920	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,035,788	1,461,175	0	1,461,175	184,856	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	35,035,788	1,461,175	0	1,461,175	184,856	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES					
1.00	Land	163,928	0				1.00
2.00	Land Improvements	603,633	0				2.00
3.00	Buildings and Fixtures	18,952,893	0				3.00
4.00	Building Improvements	96,997	0				4.00
5.00	Fixed Equipment	3,907,604	0				5.00
6.00	Movable Equipment	11,355,132	0				6.00
7.00	HIT designated Assets	1,231,920	0				7.00
8.00	Subtotal (sum of lines 1-7)	36,312,107	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	36,312,107	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part II
Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0	0	1.02
1.03	NEW CAP REL COSTS - WEST CAMPUS BUIL	0	0	0	0	0	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	1,436,165	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,436,165	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		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	0				1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0				1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0				1.02
1.03	NEW CAP REL COSTS - WEST CAMPUS BUIL	0	0				1.03
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,436,165				2.00
3.00	Total (sum of lines 1-2)	0	1,436,165				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part III
Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	23,725,055	0	23,725,055	0.653365	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0.000000	0	1.02
1.03	NEW CAP REL COSTS - WEST CAMPUS BUIL	0	0	0	0.000000	0	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	12,587,052	0	12,587,052	0.346635	0	2.00
3.00	Total (sum of lines 1-2)	36,312,107	0	36,312,107	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	386,454	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	41,542	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	240,112	0	1.02
1.03	NEW CAP REL COSTS - WEST CAMPUS BUIL	0	0	0	46,905	0	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	702,427	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,417,440	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	29,303	0	0	14,626	430,383	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	41,542	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	49,706	0	0	0	289,818	1.02
1.03	NEW CAP REL COSTS - WEST CAMPUS BUIL	0	0	0	0	46,905	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	702,427	2.00
3.00	Total (sum of lines 1-2)	79,009	0	0	14,626	1,511,075	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1313

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

Worksheet A-8

Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-CLINIC BUILDING (chapter 2)			0NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-NEW MED SURG (chapter 2)			0NEW CAP REL COSTS-NEW MED SURG	1.02	0	1.02
1.03	Investment income - NEW CAP REL COSTS - WEST CAMPUS BUIL (chapter 2)			0NEW CAP REL COSTS - WEST CAMPUS BUIL	1.03	0	1.03
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			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	-671,174			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)			0	0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1		0		0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests			0	0.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00	Sale of drugs to other than patients			0	0.00	0	17.00
18.00	Sale of medical records and abstracts			0	0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00	Vending machines			0	0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	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 - NEW CAP REL COSTS-CLINIC BUILDING			0NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-NEW MED SURG			0NEW CAP REL COSTS-NEW MED SURG	1.02	0	26.02
26.03	Depreciation - NEW CAP REL COSTS - WEST CAMPUS BUIL			0NEW CAP REL COSTS - WEST CAMPUS BUIL	1.03	0	26.03

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1313

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

Worksheet A-8

Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
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	B		0CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MEDICAL RECORD FEES -OTHER OP	B	-2,952	MEDICAL RECORDS & LIBRARY	16.00	0	33.00
33.01	CAFETERIA SALES -OTHER OP	B	-139,379	DIETARY	10.00	0	33.01
33.02	DIETARY CONSULT -OTHER OP	B		0DIETARY	10.00	0	33.02
33.03	SALE OF NON-PAT SUPP-OTHER OP	B	2,008	ADMINISTRATIVE AND GENERAL	5.01	0	33.03
33.04	ON-CALL CRNA SERVICES	A	-35,371	NONPHYSICIAN ANESTHETISTS	19.00	0	33.04
33.05	PROF BUILDING RENT -OTHER OP	B	-17,523	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
33.06	MISCELLANEOUS -OTHER OP	B	-504	ADMINISTRATIVE AND GENERAL	5.01	0	33.06
33.07	RENTAL INCOME	B		0CAP REL COSTS-BLDG & FIXT	1.00	9	33.07
33.08	COMMUNITY ED FEES -OTHER OP	B		0ADMINISTRATIVE AND GENERAL	5.01	0	33.08
33.09	LAB OUTREACH REV -OTHER OP	B	-9,770	LABORATORY	60.00	0	33.09
33.10	INTEREST INCOME -NON OPER	B	-31,786	CAP REL COSTS-BLDG & FIXT	1.00	11	33.10
33.11	INTEREST INCOME -NON OPER	B	-53,918	NEW CAP REL COSTS-NEW MED SURG	1.02	11	33.11
33.12	FITNESS EXPENSE	A	-1,662	CARDIOPULMONARY	69.01	0	33.12
33.13	FITNESS CENTER REV	B		0CARDIOPULMONARY	69.01	0	33.13
33.14	HOME HEALTH REV	B		0HOME HEALTH AGENCY	101.00	0	33.14
33.15	TELEPHONE OFFSET - OPERATIONS	A	-538	OPERATION OF PLANT	7.00	0	33.15
33.16	TELEPHONE OFFSET - SALARIES	A	-134	ADMINISTRATIVE AND GENERAL	5.01	0	33.16
33.17	TELEPHONE OFFSET - BENEFITS	A	-23	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	MEDICAR - EXPENSES	A	-6,320	ADMINISTRATIVE AND GENERAL	5.01	0	33.18
33.19	MEDICAR - BENEFITS	A	-820	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.19
33.20	LOBBYING DUES	A	-8,440	ADMINISTRATIVE AND GENERAL	5.01	0	33.20
33.21	ADVERTISING	A	-27,137	ADMINISTRATIVE AND GENERAL	5.01	0	33.21
33.22	ADVERTISING	A		0A&G HOSPITAL ONLY	5.02	0	33.22
33.25	ADVERTISING	A		0RURAL HEALTH CLINIC III	88.02	0	33.25
33.27	SPEECH THERAPY IN SCHOOLS	B		0SPEECH PATHOLOGY	68.00	0	33.27
33.34	SPEECH THERAPY IN SCHOOLS	B		0SPEECH PATHOLOGY	68.00	0	33.34
33.35	TELEVISIONS	A	-1,202	NEW CAP REL COSTS-NEW MED SURG	1.02	9	33.35
33.36	SELF INSURANCE	A	-692,223	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.36
33.37	UNFUNDED POST-EMPLOYMENT BENEFIT	A	-109,059	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.37
33.38	NON-ALLOW DONATION EXP	A		0ADMINISTRATIVE AND GENERAL	5.01	0	33.38
33.39	BOND AMORTIZATION COST FY14	A	14,626	CAP REL COSTS-BLDG & FIXT	1.00	14	33.39
33.40	IMRF CONTRIBUTION	A	1,793,370	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.40
33.41	340 B	A	-63,237	DRUGS CHARGED TO PATIENTS	73.00	0	33.41
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-63,168				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1313

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

Worksheet A-8-2

Date/Time Prepared:
2/28/2022 9:53 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,569,000	192,516	1,376,484	0	0	1.00
2.00	60.00	LABORATORY	48,000	0	48,000	0	0	2.00
3.00	69.01	CARDIOPULMONARY	28,824	28,824	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	1,994	1,994	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	349,440	349,440	0	0	0	5.00
6.00	76.03	WOUND CARE	98,400	98,400	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			2,095,658	671,174	1,424,484		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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.01	CARDIOPULMONARY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	76.03	WOUND CARE	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	91.00	EMERGENCY	0	0	0	192,516		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	69.01	CARDIOPULMONARY	0	0	0	28,824		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,994		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	349,440		5.00
6.00	76.03	WOUND CARE	0	0	0	98,400		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	671,174		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	NEW CAP REL COSTS - WEST CAMPUS BUIL	
		0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	430,383	430,383			1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	41,542	0	41,542		1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	289,818	0	0	289,818	1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL	46,905	0	0		1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP	702,427			46,905	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,336,693	0	0	0	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	1,969,739	95,396	2,204	0	5.01
5.02	00591	A&G HOSPITAL ONLY	619,348	9,763	2,714	2,379	5.02
6.00	00600	MAINTENANCE & REPAIRS	554,907	0	0	0	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	238,441	42,623	348	6,344	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	21,339	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	14,897	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	47,616	12,831	0	2,357	8.00
9.00	00900	HOUSEKEEPING	386,975	2,846	0	1,393	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	9.01
10.00	01000	DIETARY	330,709	20,859	0	0	10.00
11.00	01100	CAFETERIA	0	8,867	0	1,607	11.00
13.00	01300	NURSING ADMINISTRATION	222,474	6,514	0	3,450	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	106,842	11,852	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	213,670	5,856	422	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	298,705	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,240,134	6,342	0	225,932	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	244,909	51,342	0	0	50.00
53.00	05300	ANESTHESIOLOGY	197	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	922,054	40,024	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	117,647	1,999	0	0	54.01
56.00	05600	RADIOISOTOPE	113,998	4,343	0	0	56.00
58.00	05800	MRI	136,746	0	0	0	58.00
60.00	06000	LABORATORY	1,923,015	23,524	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	65,612	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	14,716	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	762,706	8,472	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	275,467	1,777	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	82,061	1,283	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	538,181	40,254	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	542,688	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	915,661	0	0	40,077	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	345,758	0	1,768	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	1,772	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	27,675	0	0	0	76.02
76.03	03951	WOUND CARE	1,595	0	0	0	76.03
76.04	03953	ALLERGY 123	555	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5,202,947	0	30,487	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	432,381	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	872,904	0	0	0	88.02
91.00	09100	EMERGENCY	2,721,512	33,616	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	467,415	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	822,071	0	3,599	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,665,807	430,383	41,542	283,539	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	6,279	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	136,786	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	46,905	194.04

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	NEW CAP REL COSTS - WEST CAMPUS BUIL	
			0	1.00	1.01	1.02	1.03	
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	27,802,593	430,383	41,542	289,818	46,905	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description			CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE AND GENERAL	Subtotal	
			2.00	4.00	4A	5.01	5A.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP	702,427					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,336,693				4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	116,961	146,184	2,330,484	2,330,484		5.01
5.02	00591	A&G HOSPITAL ONLY	0	63,827	698,031	63,864	761,895	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	43,823	598,730	54,779	653,509	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	13,574	0	301,330	27,569	328,899	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	21,339	1,952	23,291	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	0	0	14,897	1,363	16,260	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,811	67,615	6,186	73,801	8.00
9.00	00900	HOUSEKEEPING	0	50,754	441,968	40,437	482,405	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	0	40,617	392,185	35,882	428,067	10.00
11.00	01100	CAFETERIA	0	0	10,474	958	11,432	11.00
13.00	01300	NURSING ADMINISTRATION	0	33,695	266,133	24,349	290,482	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,221	134,915	12,344	147,259	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	57,365	22,092	299,405	27,393	326,798	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	298,705	27,329	326,034	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,609	167,496	1,662,513	152,107	1,814,620	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	87,872	28,973	413,096	37,795	450,891	50.00
53.00	05300	ANESTHESIOLOGY	0	0	197	18	215	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	172,308	92,002	1,226,388	112,205	1,338,593	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	12,394	132,040	12,081	144,121	54.01
56.00	05600	RADIOISOTOPE	0	0	118,341	10,827	129,168	56.00
58.00	05800	MRI	0	156	136,902	12,525	149,427	58.00
60.00	06000	LABORATORY	33,792	145,007	2,125,338	194,451	2,319,789	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	65,612	6,003	71,615	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	14,716	1,346	16,062	64.00
66.00	06600	PHYSICAL THERAPY	64,944	103,754	939,876	85,991	1,025,867	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	40,271	317,515	29,050	346,565	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,403	95,747	8,760	104,507	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	578,435	52,922	631,357	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	542,688	49,652	592,340	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	55,018	1,010,756	92,476	1,103,232	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	35,362	382,888	35,031	417,919	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	225	1,997	183	2,180	76.01
76.02	03950	DIABETIC EDUCATION	0	3,403	31,078	2,843	33,921	76.02
76.03	03951	WOUND CARE	0	0	1,595	146	1,741	76.03
76.04	03953	ALLERGY 123	0	0	555	51	606	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	37,551	657,213	5,928,198	542,374	6,470,572	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,710	55,072	489,163	44,755	533,918	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	106,199	979,103	89,580	1,068,683	88.02
91.00	09100	EMERGENCY	9,668	199,470	2,964,266	271,207	3,235,473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	75,914	58,391	601,720	55,053	656,773	95.00
101.00	10100	HOME HEALTH AGENCY	8,159	120,048	953,877	87,272	1,041,149	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	702,427	2,314,881	27,590,811	2,311,109	27,571,436	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	6,279	574	6,853	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	21,812	158,598	14,510	173,108	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	46,905	4,291	51,196	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments			0		0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1313

Period:
From 10/01/2020
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Cost Center Description			CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE AND GENERAL	Subtotal	202.00
			MVBLE EQUIP					
			2.00					
202.00	TOTAL (sum lines 118 through 201)		702,427	2,336,693	27,802,593	2,330,484	27,802,593	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1313

Period:
From 10/01/2020
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Cost Center Description			A&G HOSPITAL ONLY	MAINTENANCE & REPAIRS	MAINTENANCE & REPAIRS - WEST CAMPUS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	
			5.02	6.00	6.01	7.00	7.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY	761,895					5.02
6.00	00600	MAINTENANCE & REPAIRS	26,525	680,034				6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0			6.01
7.00	00700	OPERATION OF PLANT	13,350	54,898	0	397,147		7.00
7.01	00701	OPERATION OF PLANT-CLINIC	945	0	0	0	24,236	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	660	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,996	16,269	0	13,962	0	8.00
9.00	00900	HOUSEKEEPING	19,580	4,016	0	3,447	0	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	17,375	24,720	0	21,215	0	10.00
11.00	01100	CAFETERIA	464	11,239	0	9,646	0	11.00
13.00	01300	NURSING ADMINISTRATION	11,790	9,289	0	7,972	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,977	14,046	0	12,055	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,264	8,763	0	5,956	313	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	13,233	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	73,654	110,273	0	94,638	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,301	60,844	0	52,218	0	50.00
53.00	05300	ANESTHESIOLOGY	9	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,332	47,431	0	40,707	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	5,850	2,369	0	2,033	0	54.01
56.00	05600	RADIOISOTOPE	5,243	5,147	0	4,417	0	56.00
58.00	05800	MRI	6,065	0	0	0	0	58.00
60.00	06000	LABORATORY	94,158	27,878	0	23,926	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,907	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	652	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	41,639	10,040	0	8,617	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,067	2,105	0	1,807	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,242	1,521	0	1,305	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	25,626	47,704	0	40,941	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,042	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,779	18,228	0	15,644	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	16,963	7,632	0	0	1,311	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	88	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	1,377	5,780	0	0	0	76.02
76.03	03951	WOUND CARE	71	0	0	0	0	76.03
76.04	03953	ALLERGY 123	25	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	131,610	0	0	22,612	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	43,377	0	0	0	0	88.02
91.00	09100	EMERGENCY	131,333	39,838	0	34,190	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	26,658	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	15,538	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	761,617	677,178	0	394,696	24,236	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	278	2,856	0	2,451	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
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)	761,895	680,034	0	397,147	24,236	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			OPERATION OF PLANT - WEST CAMPUS BUI	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	HOUSEKEEPING - WEST CAMPUS BUILDING	DIETARY	
			7.02	8.00	9.00	9.01	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS						6.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	16,920					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	107,028				8.00
9.00	00900	HOUSEKEEPING	0	0	509,448			9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0		9.01
10.00	01000	DIETARY	0	0	21,021	0	512,398	10.00
11.00	01100	CAFETERIA	0	0	9,557	0	413,473	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	7,900	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	11,945	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	7,452	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	46,215	93,776	0	95,041	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	13,807	51,741	0	553	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,623	40,335	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	2,014	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	4,377	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	204	23,707	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	3,308	8,538	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,790	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,293	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	1,013	40,568	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	15,501	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	6,490	0	3,331	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	0	76.02
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	2,300	111,923	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	103	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	27,221	33,878	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	178	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	43	13,213	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	107,015	507,019	0	512,398	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,429	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	16,920	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,920	107,028	509,448	0	512,398	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS						6.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING						9.01
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	455,811					11.00
13.00	01300	NURSING ADMINISTRATION	5,606	333,039				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,986	0	198,268			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,719	0	0	0	370,265	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	53,892	203,485	0	0	22,845	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,437	38,217	0	0	11,447	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	7,242	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,876	0	2,064	0	59,036	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	3,296	0	790	0	7,677	54.01
56.00	05600	RADIOISOTOPE	28	0	5,358	0	4,294	56.00
58.00	05800	MRI	113	0	488	0	10,754	58.00
60.00	06000	LABORATORY	51,328	0	95,202	0	74,434	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	10,090	0	905	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	871	0	3,187	64.00
66.00	06600	PHYSICAL THERAPY	25,636	0	0	0	18,741	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,508	0	0	0	7,848	67.00
68.00	06800	SPEECH PATHOLOGY	2,845	0	0	0	2,932	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	21,016	0	0	0	13,192	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	83,405	0	5,165	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,423	0	0	0	10,225	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	10,959	26,525	0	0	3,160	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	85	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	901	0	0	0	11	76.02
76.03	03951	WOUND CARE	0	0	0	0	2,748	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	128,545	0	0	0	36,282	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	2,290	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	5,906	88.02
91.00	09100	EMERGENCY	81,612	64,812	0	0	20,516	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	18,977	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	20,451	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	455,811	333,039	198,268	0	370,265	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	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
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)	455,811	333,039	198,268	0	370,265	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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To 09/30/2021Worksheet B
Part I
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Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING					1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL					1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	ADMINISTRATIVE AND GENERAL					5.01
5.02	00591	A&G HOSPITAL ONLY					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS					6.01
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT-CLINIC					7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI					7.02
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING					9.01
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	339,267				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,608,439	0	2,608,439	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	705,456	0	705,456	50.00
53.00	05300	ANESTHESIOLOGY	339,267	346,733	0	346,733	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,623,997	0	1,623,997	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	168,150	0	168,150	54.01
56.00	05600	RADIOISOTOPE	0	158,032	0	158,032	56.00
58.00	05800	MRI	0	166,847	0	166,847	58.00
60.00	06000	LABORATORY	0	2,710,626	0	2,710,626	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	85,517	0	85,517	62.00
64.00	06400	INTRAVENOUS THERAPY	0	20,772	0	20,772	64.00
66.00	06600	PHYSICAL THERAPY	0	1,142,386	0	1,142,386	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	382,690	0	382,690	67.00
68.00	06800	SPEECH PATHOLOGY	0	118,645	0	118,645	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	821,417	0	821,417	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	704,952	0	704,952	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,218,032	0	1,218,032	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	494,290	0	494,290	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	2,353	0	2,353	76.01
76.02	03950	DIABETIC EDUCATION	0	41,990	0	41,990	76.02
76.03	03951	WOUND CARE	0	4,560	0	4,560	76.03
76.04	03953	ALLERGY 123	0	631	0	631	76.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6,903,844	0	6,903,844	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	536,311	0	536,311	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,117,966	0	1,117,966	88.02
91.00	09100	EMERGENCY	0	3,668,873	0	3,668,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	702,586	0	702,586	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,090,394	0	1,090,394	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	339,267	27,546,489	0	27,546,489	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,867	0	14,867	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	173,121	0	173,121	192.00
194.00	07950	HOSPICE	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	68,116	0	68,116	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		19.00	24.00	25.00	26.00		
202.00	TOTAL (sum lines 118 through 201)	339,267	27,802,593	0	27,802,593		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description			CAPITAL RELATED COSTS					
			Directly Assigned New Capital Related Costs	BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG		NEW CAP REL COSTS - WEST CAMPUS BUIL
			0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	0	95,396	2,204	0	0	5.01
5.02	00591	A&G HOSPITAL ONLY	0	9,763	2,714	2,379	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	0	42,623	348	6,344	0	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,831	0	2,357	0	8.00
9.00	00900	HOUSEKEEPING	0	2,846	0	1,393	0	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	0	20,859	0	0	0	10.00
11.00	01100	CAFETERIA	0	8,867	0	1,607	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,514	0	3,450	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,852	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,856	422	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	6,342	0	225,932	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	51,342	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	40,024	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	1,999	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	4,343	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	23,524	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	8,472	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,777	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,283	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	40,254	0	0	0	69.01
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	40,077	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	1,768	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	0	76.02
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	30,487	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	33,616	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	3,599	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	430,383	41,542	283,539	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	6,279	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	46,905	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	NEW CAP REL COSTS - WEST CAMPUS BUIL	
			1.00	1.01	1.02	1.03	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	430,383	41,542	289,818	46,905	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description			CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE AND GENERAL	A&G HOSPITAL ONLY	
			2.00	2A	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0			4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	116,961	214,561	0	214,561		5.01
5.02	00591	A&G HOSPITAL ONLY	0	14,856	0	5,880	20,736	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	5,043	722	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	13,574	62,889	0	2,538	363	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	180	26	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	0	0	0	125	18	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,188	0	570	82	8.00
9.00	00900	HOUSEKEEPING	0	4,239	0	3,723	533	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	0	20,859	0	3,303	473	10.00
11.00	01100	CAFETERIA	0	10,474	0	88	13	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,964	0	2,242	321	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,852	0	1,136	163	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	57,365	63,643	0	2,522	361	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	2,516	360	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,609	254,883	0	14,003	2,005	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	87,872	139,214	0	3,480	498	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	172,308	212,332	0	10,330	1,479	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	1,999	0	1,112	159	54.01
56.00	05600	RADIOISOTOPE	0	4,343	0	997	143	56.00
58.00	05800	MRI	0	0	0	1,153	165	58.00
60.00	06000	LABORATORY	33,792	57,316	0	17,902	2,563	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	553	79	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	124	18	64.00
66.00	06600	PHYSICAL THERAPY	64,944	73,416	0	7,917	1,134	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,777	0	2,674	383	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,283	0	806	115	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	40,254	0	4,872	698	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,571	655	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	40,077	0	8,514	1,219	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,768	0	3,225	462	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	17	2	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	262	37	76.02
76.03	03951	WOUND CARE	0	0	0	13	2	76.03
76.04	03953	ALLERGY 123	0	0	0	5	1	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	37,551	68,038	0	49,941	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,710	1,710	0	4,120	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	8,247	1,181	88.02
91.00	09100	EMERGENCY	9,668	43,284	0	24,968	3,569	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	75,914	75,914	0	5,068	726	95.00
101.00	10100	HOME HEALTH AGENCY	8,159	11,758	0	8,035	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	702,427	1,457,891	0	212,777	20,728	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,279	0	53	8	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,336	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	46,905	0	395	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0	0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description			CAPITAL RELATED COSTS	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE AND GENERAL	A&G HOSPITAL ONLY	
			MVBLE EQUIP					
			2.00	2A	4.00	5.01	5.02	
202.00	TOTAL (sum lines 118 through 201)		702,427	1,511,075	0	214,561	20,736	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description			MAINTENANCE & REPAIRS	MAINTENANCE & REPAIRS - WEST CAMPUS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	OPERATION OF PLANT - WEST CAMPUS BUI	
			6.00	6.01	7.00	7.01	7.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS	5,765					6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0				6.01
7.00	00700	OPERATION OF PLANT	465	0	66,255			7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	206		7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	0	0	0	0	143	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	138	0	2,329	0	0	8.00
9.00	00900	HOUSEKEEPING	34	0	575	0	0	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	210	0	3,539	0	0	10.00
11.00	01100	CAFETERIA	95	0	1,609	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	79	0	1,330	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	119	0	2,011	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	74	0	994	3	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	935	0	15,790	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	516	0	8,711	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	402	0	6,791	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	20	0	339	0	0	54.01
56.00	05600	RADIOISOTOPE	44	0	737	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	236	0	3,991	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	85	0	1,437	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	18	0	301	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	13	0	218	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	404	0	6,830	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	155	0	2,610	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	65	0	0	11	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	49	0	0	0	0	76.02
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,115	0	0	192	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	338	0	5,704	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	132	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,741	0	65,846	206	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	24	0	409	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	143	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
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)	5,765	0	66,255	206	143	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	HOUSEKEEPING - WEST CAMPUS BUILDING	DIETARY	CAFETERIA	
			8.00	9.00	9.01	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS						6.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	18,307					8.00
9.00	00900	HOUSEKEEPING	0	9,104				9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0			9.01
10.00	01000	DIETARY	0	376	0	28,760		10.00
11.00	01100	CAFETERIA	0	171	0	23,207	35,657	11.00
13.00	01300	NURSING ADMINISTRATION	0	141	0	0	439	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	213	0	0	547	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	133	0	0	604	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,906	1,676	0	5,335	4,216	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,362	925	0	31	582	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,159	721	0	0	2,259	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	36	0	0	258	54.01
56.00	05600	RADIOISOTOPE	0	78	0	0	2	56.00
58.00	05800	MRI	0	0	0	0	9	58.00
60.00	06000	LABORATORY	35	424	0	0	4,015	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	566	153	0	0	2,005	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	32	0	0	666	67.00
68.00	06800	SPEECH PATHOLOGY	0	23	0	0	223	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	173	725	0	0	1,644	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	277	0	0	815	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	116	0	187	857	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	7	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	71	76.02
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	393	2,000	0	0	10,054	88.00
88.01	08801	RURAL HEALTH CLINIC II	18	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	4,656	605	0	0	6,384	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	30	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	7	236	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,305	9,061	0	28,760	35,657	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
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)	18,307	9,104	0	28,760	35,657	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS						6.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING						9.01
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	14,516					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,041				14.00
15.00	01500	PHARMACY	0	0	0			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	68,334		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	2,876	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,869	0	0	4,217		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,666	0	0	2,113		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,337		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	167	0	10,897		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	64	0	1,417		54.01
56.00	05600	RADIOISOTOPE	0	433	0	793		56.00
58.00	05800	MRI	0	39	0	1,985		58.00
60.00	06000	LABORATORY	0	7,703	0	13,729		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	816	0	167		62.00
64.00	06400	INTRAVENOUS THERAPY	0	71	0	588		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,459		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,449		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	541		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	0	0	2,435		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,748	0	953		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,887		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,156	0	0	583		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0		76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	2		76.02
76.03	03951	WOUND CARE	0	0	0	507		76.03
76.04	03953	ALLERGY 123	0	0	0	0		76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	6,697		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	423		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,090		88.02
91.00	09100	EMERGENCY	2,825	0	0	3,787		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	3,503		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	3,775		101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,516	16,041	0	68,334	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	HOSPICE	0	0	0	0		194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0		194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0		194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0		194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0		194.04
200.00		Cross Foot Adjustments					2,876	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,516	16,041	0	68,334	2,876	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING				1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG				1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL				1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	ADMINISTRATIVE AND GENERAL				5.01
5.02	00591	A&G HOSPITAL ONLY				5.02
6.00	00600	MAINTENANCE & REPAIRS				6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS				6.01
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT-CLINIC				7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI				7.02
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING				9.01
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	319,835	0	319,835	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	160,098	0	160,098	50.00
53.00	05300	ANESTHESIOLOGY	1,339	0	1,339	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	247,537	0	247,537	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	5,404	0	5,404	54.01
56.00	05600	RADIOISOTOPE	7,570	0	7,570	56.00
58.00	05800	MRI	3,351	0	3,351	58.00
60.00	06000	LABORATORY	107,914	0	107,914	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,615	0	1,615	62.00
64.00	06400	INTRAVENOUS THERAPY	801	0	801	64.00
66.00	06600	PHYSICAL THERAPY	90,172	0	90,172	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,300	0	7,300	67.00
68.00	06800	SPEECH PATHOLOGY	3,222	0	3,222	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	58,035	0	58,035	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,927	0	12,927	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,554	0	55,554	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8,430	0	8,430	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	26	0	26	76.01
76.02	03950	DIABETIC EDUCATION	421	0	421	76.02
76.03	03951	WOUND CARE	522	0	522	76.03
76.04	03953	ALLERGY 123	6	0	6	76.04
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	138,430	0	138,430	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,271	0	6,271	88.01
88.02	08802	RURAL HEALTH CLINIC III	10,518	0	10,518	88.02
91.00	09100	EMERGENCY	96,120	0	96,120	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	85,241	0	85,241	95.00
101.00	10100	HOME HEALTH AGENCY	23,943	0	23,943	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,452,602	0	1,452,602	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,816	0	6,816	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,338	0	1,338	192.00
194.00	07950	HOSPICE	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	47,443	0	47,443	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	194.04
200.00		Cross Foot Adjustments	2,876	0	2,876	200.00
201.00		Negative Cost Centers	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
202.00	TOTAL (sum lines 118 through 201)	1,511,075	0	1,511,075		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1313

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	NEW CAP REL COSTS - WEST CAMPUS BUIL (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	
			1.00	1.01	1.02	1.03	2.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	52,325					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	18,398				1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	0	0	13,523			1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL	0	0	0	21,089		1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP					706,310	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	11,598	976	0	0	117,608	5.01
5.02	00591	A&G HOSPITAL ONLY	1,187	1,202	111	0	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	5,182	154	296	0	13,649	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	1,560	0	110	0	0	8.00
9.00	00900	HOUSEKEEPING	346	0	65	0	0	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	2,536	0	0	0	0	10.00
11.00	01100	CAFETERIA	1,078	0	75	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	792	0	161	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,441	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	712	187	0	0	57,682	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	771	0	10,542	0	22,734	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,242	0	0	0	88,358	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,866	0	0	0	173,260	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	528	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,860	0	0	0	33,979	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,030	0	0	0	65,303	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,894	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,870	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	783	0	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	0	76.02
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	13,502	0	0	37,759	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	1,719	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	4,087	0	0	0	9,721	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	76,334	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,594	0	0	8,204	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,325	18,398	13,230	0	706,310	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	293	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	21,089	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1313

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	NEW CAP REL COSTS - WEST CAMPUS BUIL (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	
			1.00	1.01	1.02	1.03	2.00	
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	430,383	41,542	289,818	46,905	702,427	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.225189	2.257963	21.431487	2.224145	0.994502	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1313

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	
			4.00	5A.01	5.01	5A.02	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,908,474					4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	870,116	-2,330,484	25,472,109			5.01
5.02	00591	A&G HOSPITAL ONLY	379,913	0	698,031	-761,895	18,770,755	5.02
6.00	00600	MAINTENANCE & REPAIRS	260,841	0	598,730	0	653,509	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	0	0	301,330	0	328,899	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	21,339	0	23,291	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	0	0	14,897	0	16,260	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	28,634	0	67,615	0	73,801	8.00
9.00	00900	HOUSEKEEPING	302,097	0	441,968	0	482,405	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	241,763	0	392,185	0	428,067	10.00
11.00	01100	CAFETERIA	0	0	10,474	0	11,432	11.00
13.00	01300	NURSING ADMINISTRATION	200,562	0	266,133	0	290,482	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	96,548	0	134,915	0	147,259	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	131,495	0	299,405	0	326,798	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	298,705	0	326,034	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	996,972	0	1,662,513	0	1,814,620	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	172,456	0	413,096	0	450,891	50.00
53.00	05300	ANESTHESIOLOGY	0	0	197	0	215	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	547,615	0	1,226,388	0	1,338,593	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	73,773	0	132,040	0	144,121	54.01
56.00	05600	RADIOISOTOPE	0	0	118,341	0	129,168	56.00
58.00	05800	MRI	929	0	136,902	0	149,427	58.00
60.00	06000	LABORATORY	863,114	0	2,125,338	0	2,319,789	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	65,612	0	71,615	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	14,716	0	16,062	64.00
66.00	06600	PHYSICAL THERAPY	617,562	0	939,876	0	1,025,867	66.00
67.00	06700	OCCUPATIONAL THERAPY	239,704	0	317,515	0	346,565	67.00
68.00	06800	SPEECH PATHOLOGY	73,824	0	95,747	0	104,507	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	578,435	0	631,357	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	542,688	0	592,340	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	327,477	0	1,010,756	0	1,103,232	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	210,483	0	382,888	0	417,919	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	1,337	0	1,997	0	2,180	76.01
76.02	03950	DIABETIC EDUCATION	20,255	0	31,078	0	33,921	76.02
76.03	03951	WOUND CARE	0	0	1,595	0	1,741	76.03
76.04	03953	ALLERGY 123	0	0	555	0	606	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,911,856	0	5,928,198	-6,470,572	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	327,800	0	489,163	-533,918	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	632,121	0	979,103	0	1,068,683	88.02
91.00	09100	EMERGENCY	1,187,288	0	2,964,266	0	3,235,473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	347,558	0	601,720	0	656,773	95.00
101.00	10100	HOME HEALTH AGENCY	714,552	0	953,877	-1,041,149	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,778,645	-2,330,484	25,260,327	-8,807,534	18,763,902	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	6,279	0	6,853	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	129,829	0	158,598	-173,108	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	46,905	-51,196	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1313

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	
		4.00	5A.01	5.01	5A.02	5.02	
202.00	Cost to be allocated (per Wkst. B, Part I)	2,336,693		2,330,484		761,895	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.168005		0.091492		0.040589	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0		214,561		20,736	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000		0.008423		0.001105	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: 14-1313

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	MAINTENANCE & REPAIRS - WEST CAMPUS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	OPERATION OF PLANT - WEST CAMPUS BUI (SQUARE FEET)	
		6.00	6.01	7.00	7.01	7.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING					1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL					1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	ADMINISTRATIVE AND GENERAL					5.01
5.02	00591	A&G HOSPITAL ONLY					5.02
6.00	00600	MAINTENANCE & REPAIRS	69,765				6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	21,089			6.01
7.00	00700	OPERATION OF PLANT	5,632	0	47,474		7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	14,472	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	1,669	0	1,669	0	8.00
9.00	00900	HOUSEKEEPING	412	0	412	0	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	9.01
10.00	01000	DIETARY	2,536	0	2,536	0	10.00
11.00	01100	CAFETERIA	1,153	0	1,153	0	11.00
13.00	01300	NURSING ADMINISTRATION	953	0	953	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,441	0	1,441	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	899	0	712	187	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,313	0	11,313	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,242	0	6,242	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,866	0	4,866	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	243	0	54.01
56.00	05600	RADIOISOTOPE	528	0	528	0	56.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	2,860	0	2,860	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,030	0	1,030	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	216	0	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	156	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,894	0	4,894	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,870	0	1,870	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	783	0	0	783	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	593	0	0	0	76.02
76.03	03951	WOUND CARE	0	0	0	0	76.03
76.04	03953	ALLERGY 123	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	13,502	0	0	13,502	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
91.00	09100	EMERGENCY	4,087	0	4,087	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	1,594	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,472	0	47,181	14,472	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	293	0	293	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	21,089	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1313

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	MAINTENANCE & REPAIRS - WEST CAMPUS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	OPERATION OF PLANT - WEST CAMPUS BUI (SQUARE FEET)	
			6.00	6.01	7.00	7.01	7.02	
202.00		Cost to be allocated (per Wkst. B, Part I)	680,034	0	397,147	24,236	16,920	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.747495	0.000000	8.365569	1.674682	0.802314	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,765	0	66,255	206	143	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.082635	0.000000	1.395606	0.014234	0.006781	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: 14-1313

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	HOUSEKEEPING - WEST CAMPUS BUILDING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		8.00	9.00	9.01	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING					1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL					1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	ADMINISTRATIVE AND GENERAL					5.01
5.02	00591	A&G HOSPITAL ONLY					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS					6.01
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT-CLINIC					7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	66,779				8.00
9.00	00900	HOUSEKEEPING	0	61,459			9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	21,089		9.01
10.00	01000	DIETARY	0	2,536	0	33,383	10.00
11.00	01100	CAFETERIA	0	1,153	0	26,938	11.00
13.00	01300	NURSING ADMINISTRATION	0	953	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,441	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	899	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	28,836	11,313	0	6,192	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,615	6,242	0	36	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,876	4,866	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	243	0	0	54.01
56.00	05600	RADIOISOTOPE	0	528	0	0	56.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	127	2,860	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	2,064	1,030	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	216	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	156	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	632	4,894	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,870	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	783	0	217	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	76.02
76.03	03951	WOUND CARE	0	0	0	0	76.03
76.04	03953	ALLERGY 123	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,435	13,502	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	64	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
91.00	09100	EMERGENCY	16,984	4,087	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	111	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	27	1,594	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,771	61,166	0	33,383	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	293	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	21,089	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1313

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	HOUSEKEEPING - WEST CAMPUS BUILDING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			8.00	9.00	9.01	10.00	11.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	107,028	509,448	0	512,398	455,811	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.602719	8.289233	0.000000	15.349070	28.171261	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	18,307	9,104	0	28,760	35,657	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.274143	0.148131	0.000000	0.861516	2.203770	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: 14-1313

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description			NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UISI)	PHARMACY (COSTED REQ UISI)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS						6.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING						9.01
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	47,799					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,289,260				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	50,362,765		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	29,205	0	0	3,107,325	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,485	0	0	1,557,022	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	985,083	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,422	0	8,029,989	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	5,135	0	1,044,151	0	54.01
56.00	05600	RADIOISOTOPE	0	34,841	0	584,071	0	56.00
58.00	05800	MRI	0	3,174	0	1,462,742	0	58.00
60.00	06000	LABORATORY	0	619,057	0	10,124,721	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	65,612	0	123,071	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	5,667	0	433,534	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,549,052	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,067,467	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	398,748	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	1,794,286	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	542,352	0	702,547	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	1,390,809	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,807	0	0	429,794	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	1,477	0	76.02
76.03	03951	WOUND CARE	0	0	0	373,753	0	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,934,973	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	311,457	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	803,256	0	88.02
91.00	09100	EMERGENCY	9,302	0	0	2,790,515	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	2,581,177	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	2,781,745	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,799	1,289,260	100	50,362,765	100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1313

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description		NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UISI)	PHARMACY (COSTED REQ UISI)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	19.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	333,039	198,268	0	370,265	339,267	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6.967489	0.153784	0.000000	0.007352	3,392.670000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	14,516	16,041	0	68,334	2,876	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.303688	0.012442	0.000000	0.001357	28.760000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 9:53 am

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,608,439		2,608,439	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	705,456		705,456	0	0	50.00
53.00	05300	ANESTHESIOLOGY	346,733		346,733	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,623,997		1,623,997	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	168,150		168,150	0	0	54.01
56.00	05600	RADIOISOTOPE	158,032		158,032	0	0	56.00
58.00	05800	MRI	166,847		166,847	0	0	58.00
60.00	06000	LABORATORY	2,710,626		2,710,626	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	85,517		85,517	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	20,772		20,772	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,142,386	0	1,142,386	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	382,690	0	382,690	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	118,645	0	118,645	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	821,417		821,417	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	704,952		704,952	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,218,032		1,218,032	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	494,290		494,290	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	2,353		2,353	0	0	76.01
76.02	03950	DIABETIC EDUCATION	41,990		41,990	0	0	76.02
76.03	03951	WOUND CARE	4,560		4,560	0	0	76.03
76.04	03953	ALLERGY 123	631		631	0	0	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,903,844		6,903,844	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	536,311		536,311	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,117,966		1,117,966	0	0	88.02
91.00	09100	EMERGENCY	3,668,873		3,668,873	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	253,021		253,021	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	702,586		702,586	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	1,090,394		1,090,394	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	27,799,510	0	27,799,510	0	0	200.00
201.00		Less Observation Beds	253,021		253,021			201.00
202.00		Total (see instructions)	27,546,489	0	27,546,489	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 9:53 am

			Title XVIII			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,762,853		2,762,853			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	96,363	1,460,659	1,557,022	0.453080	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	71,539	913,544	985,083	0.351984	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	421,612	7,608,377	8,029,989	0.202241	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	48,799	995,352	1,044,151	0.161040	0.000000	54.01
56.00	05600	RADIOISOTOPE	2,868	581,203	584,071	0.270570	0.000000	56.00
58.00	05800	MRI	38,981	1,423,761	1,462,742	0.114065	0.000000	58.00
60.00	06000	LABORATORY	813,831	9,310,890	10,124,721	0.267724	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	47,546	75,525	123,071	0.694859	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	37,834	395,700	433,534	0.047913	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	394,590	2,154,462	2,549,052	0.448161	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	403,473	663,994	1,067,467	0.358503	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	13,250	385,498	398,748	0.297544	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	357,812	1,436,474	1,794,286	0.457796	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	317,679	384,868	702,547	1.003423	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	570,990	819,819	1,390,809	0.875772	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	429,794	429,794	1.150063	0.000000	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0.000000	0.000000	76.01
76.02	03950	DIABETIC EDUCATION	0	1,477	1,477	28.429248	0.000000	76.02
76.03	03951	WOUND CARE	0	373,753	373,753	0.012201	0.000000	76.03
76.04	03953	ALLERGY 123	0	0	0	0.000000	0.000000	76.04
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,934,973	4,934,973			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	311,457	311,457			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	803,256	803,256			88.02
91.00	09100	EMERGENCY	29,928	2,760,587	2,790,515	1.314766	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	344,472	344,472	0.734518	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,059	2,580,118	2,581,177	0.272196	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	2,781,745	2,781,745			101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,431,007	43,931,758	50,362,765			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,431,007	43,931,758	50,362,765			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-1313	Period: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Prepared: 2/28/2022 9:53 am
			Title XVIII	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio		
			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
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	03160	CARDIOPULMONARY	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000		76.01
76.02	03950	DIABETIC EDUCATION	0.000000		76.02
76.03	03951	WOUND CARE	0.000000		76.03
76.04	03953	ALLERGY 123	0.000000		76.04
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 9:53 am

			Title XIX		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	2,608,439		2,608,439	0	2,608,439	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	705,456		705,456	0	705,456	50.00
53.00	05300	ANESTHESIOLOGY	346,733		346,733	0	346,733	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,623,997		1,623,997	0	1,623,997	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	168,150		168,150	0	168,150	54.01
56.00	05600	RADIOISOTOPE	158,032		158,032	0	158,032	56.00
58.00	05800	MRI	166,847		166,847	0	166,847	58.00
60.00	06000	LABORATORY	2,710,626		2,710,626	0	2,710,626	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	85,517		85,517	0	85,517	62.00
64.00	06400	INTRAVENOUS THERAPY	20,772		20,772	0	20,772	64.00
66.00	06600	PHYSICAL THERAPY	1,142,386	0	1,142,386	0	1,142,386	66.00
67.00	06700	OCCUPATIONAL THERAPY	382,690	0	382,690	0	382,690	67.00
68.00	06800	SPEECH PATHOLOGY	118,645	0	118,645	0	118,645	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	821,417		821,417	0	821,417	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	704,952		704,952	0	704,952	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,218,032		1,218,032	0	1,218,032	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	494,290		494,290	0	494,290	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	2,353		2,353	0	2,353	76.01
76.02	03950	DIABETIC EDUCATION	41,990		41,990	0	41,990	76.02
76.03	03951	WOUND CARE	4,560		4,560	0	4,560	76.03
76.04	03953	ALLERGY 123	631		631	0	631	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,903,844		6,903,844	0	6,903,844	88.00
88.01	08801	RURAL HEALTH CLINIC II	536,311		536,311	0	536,311	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,117,966		1,117,966	0	1,117,966	88.02
91.00	09100	EMERGENCY	3,668,873		3,668,873	0	3,668,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	253,021		253,021	0	253,021	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	702,586		702,586	0	702,586	95.00
101.00	10100	HOME HEALTH AGENCY	1,090,394		1,090,394	0	1,090,394	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	27,799,510	0	27,799,510	0	27,799,510	200.00
201.00		Less Observation Beds	253,021		253,021		253,021	201.00
202.00		Total (see instructions)	27,546,489	0	27,546,489	0	27,546,489	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 9:53 am

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,762,853		2,762,853			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	96,363	1,460,659	1,557,022	0.453080	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	71,539	913,544	985,083	0.351984	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	421,612	7,608,377	8,029,989	0.202241	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	48,799	995,352	1,044,151	0.161040	0.000000	54.01
56.00	05600	RADIOISOTOPE	2,868	581,203	584,071	0.270570	0.000000	56.00
58.00	05800	MRI	38,981	1,423,761	1,462,742	0.114065	0.000000	58.00
60.00	06000	LABORATORY	813,831	9,310,890	10,124,721	0.267724	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	47,546	75,525	123,071	0.694859	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	37,834	395,700	433,534	0.047913	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	394,590	2,154,462	2,549,052	0.448161	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	403,473	663,994	1,067,467	0.358503	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	13,250	385,498	398,748	0.297544	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	357,812	1,436,474	1,794,286	0.457796	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	317,679	384,868	702,547	1.003423	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	570,990	819,819	1,390,809	0.875772	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	429,794	429,794	1.150063	0.000000	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0.000000	0.000000	76.01
76.02	03950	DIABETIC EDUCATION	0	1,477	1,477	28.429248	0.000000	76.02
76.03	03951	WOUND CARE	0	373,753	373,753	0.012201	0.000000	76.03
76.04	03953	ALLERGY 123	0	0	0	0.000000	0.000000	76.04
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,934,973	4,934,973	1.398963	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	311,457	311,457	1.721942	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	803,256	803,256	1.391793	0.000000	88.02
91.00	09100	EMERGENCY	29,928	2,760,587	2,790,515	1.314766	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	344,472	344,472	0.734518	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,059	2,580,118	2,581,177	0.272196	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	2,781,745	2,781,745			101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,431,007	43,931,758	50,362,765			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,431,007	43,931,758	50,362,765			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	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
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
69.01	03160	CARDIOPULMONARY	0.000000			69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000			76.01
76.02	03950	DIABETIC EDUCATION	0.000000			76.02
76.03	03951	WOUND CARE	0.000000			76.03
76.04	03953	ALLERGY 123	0.000000			76.04
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000			88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000			88.02
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
101.00	10100	HOME HEALTH AGENCY				101.00
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: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part II
Date/Time Prepared:
2/28/2022 9:53 am

				Title XVIII		Hospital	Cost	
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)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	160,098	1,557,022	0.102823	48,631	5,000	50.00
53.00	05300	ANESTHESIOLOGY	1,339	985,083	0.001359	40,075	54	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	247,537	8,029,989	0.030827	219,498	6,766	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	5,404	1,044,151	0.005175	20,681	107	54.01
56.00	05600	RADIOISOTOPE	7,570	584,071	0.012961	2,868	37	56.00
58.00	05800	MRI	3,351	1,462,742	0.002291	15,251	35	58.00
60.00	06000	LABORATORY	107,914	10,124,721	0.010658	362,824	3,867	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,615	123,071	0.013123	20,947	275	62.00
64.00	06400	INTRAVENOUS THERAPY	801	433,534	0.001848	2,921	5	64.00
66.00	06600	PHYSICAL THERAPY	90,172	2,549,052	0.035375	106,452	3,766	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,300	1,067,467	0.006839	91,926	629	67.00
68.00	06800	SPEECH PATHOLOGY	3,222	398,748	0.008080	5,860	47	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	58,035	1,794,286	0.032344	182,609	5,906	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,927	702,547	0.018400	145,809	2,683	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,554	1,390,809	0.039944	238,234	9,516	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8,430	429,794	0.019614	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	26	0	0.000000	0	0	76.01
76.02	03950	DIABETIC EDUCATION	421	1,477	0.285037	0	0	76.02
76.03	03951	WOUND CARE	522	373,753	0.001397	0	0	76.03
76.04	03953	ALLERGY 123	6	0	0.000000	0	0	76.04
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	138,430	4,934,973	0.028051	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,271	311,457	0.020134	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	10,518	803,256	0.013094	0	0	88.02
91.00	09100	EMERGENCY	96,120	2,790,515	0.034445	1,222	42	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	31,024	344,472	0.090062	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,054,607	42,236,990		1,505,808	38,735	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	339,267	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	0	0 54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0 62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0 69.01
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
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0 76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0 76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	0 76.02
76.03	03951	WOUND CARE	0	0	0	0	0 76.03
76.04	03953	ALLERGY 123	0	0	0	0	0 76.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0 88.02
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
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
200.00		Total (lines 50 through 199)	339,267	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1313		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 9:53 am	
			Title XVIII		Hospital		Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	1,557,022	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	339,267	0	985,083	0.344404	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,029,989	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	1,044,151	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	584,071	0.000000	56.00
58.00	05800	MRI	0	0	0	1,462,742	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	10,124,721	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	123,071	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	433,534	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,549,052	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,067,467	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	398,748	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	1,794,286	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	702,547	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,390,809	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	429,794	0.000000	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0.000000	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	1,477	0.000000	76.02
76.03	03951	WOUND CARE	0	0	0	373,753	0.000000	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0.000000	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,934,973	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	311,457	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	803,256	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	2,790,515	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	344,472	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	339,267	0	42,236,990		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Title XVIII			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	48,631	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	40,075	13,802	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	219,498	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000	20,681	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	2,868	0	0	0	56.00
58.00	05800	MRI	0.000000	15,251	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	362,824	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	20,947	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	2,921	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	106,452	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	91,926	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	5,860	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.000000	182,609	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	145,809	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	238,234	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0.000000	0	0	0	0	76.02
76.03	03951	WOUND CARE	0.000000	0	0	0	0	76.03
76.04	03953	ALLERGY 123	0.000000	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
91.00	09100	EMERGENCY	0.000000	1,222	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,505,808	13,802	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/28/2022 9:53 am

			Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.453080	0	581,971	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.351984	0	348,556	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202241	0	2,937,430	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.161040	0	334,883	0	0	54.01
56.00	05600	RADIOISOTOPE	0.270570	0	262,145	0	0	56.00
58.00	05800	MRI	0.114065	0	560,610	0	0	58.00
60.00	06000	LABORATORY	0.267724	0	3,451,701	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.694859	0	52,527	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.047913	0	132,138	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.448161	0	798,243	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.358503	0	45,464	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.297544	0	2,622	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.457796	0	621,346	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.003423	0	136,597	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.875772	0	601,869	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.150063	0	428,445	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	28.429248	0	658	0	0	76.02
76.03	03951	WOUND CARE	0.012201	0	237,457	0	0	76.03
76.04	03953	ALLERGY 123	0.000000	0	0	0	0	76.04
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
91.00	09100	EMERGENCY	1.314766	0	775,154	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.734518	0	109,201	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.272196		0			95.00
200.00		Subtotal (see instructions)		0	12,419,017	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	12,419,017	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-1313		Period: From 10/01/2020 To 09/30/2021	Worksheet D Part V Date/Time Prepared: 2/28/2022 9:53 am
			Title XVIII		Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	263,679	0		50.00
53.00	05300	ANESTHESIOLOGY	122,686	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	594,069	0		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	53,930	0		54.01
56.00	05600	RADIOISOTOPE	70,929	0		56.00
58.00	05800	MRI	63,946	0		58.00
60.00	06000	LABORATORY	924,103	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	36,499	0		62.00
64.00	06400	INTRAVENOUS THERAPY	6,331	0		64.00
66.00	06600	PHYSICAL THERAPY	357,741	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	16,299	0		67.00
68.00	06800	SPEECH PATHOLOGY	780	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	284,450	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	137,065	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	527,100	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	492,739	0		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0		76.01
76.02	03950	DIABETIC EDUCATION	18,706	0		76.02
76.03	03951	WOUND CARE	2,897	0		76.03
76.04	03953	ALLERGY 123	0	0		76.04
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
91.00	09100	EMERGENCY	1,019,146	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	80,210	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,073,305	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,073,305	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1313	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 9:53 am	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,551	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			934	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.			26	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			764	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			136	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)			407	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			19	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)			55	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			441	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)			134	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)			403	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)			26	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)			2,608,439	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)			3,393	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)			9,822	25.00
26.00	Total swing-bed cost (see instructions)			967,315	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,641,124	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			1,683,959	28.00
29.00	Private room charges (excluding swing-bed charges)			65,679	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			1,618,280	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.974563	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			2,526.12	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			2,118.17	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			407.95	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			397.57	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			10,337	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,630,787	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)			1,746.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			769,995	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			10,337	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			780,332	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1313

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

Worksheet D-1

Date/Time Prepared:
2/28/2022 9:53 am

			Title XVIII		Hospital	Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					720,769	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,501,101	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)					233,967	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					703,646	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					937,613	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)					144	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,757.09	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					253,021	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1313

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

Worksheet D-1

Date/Time Prepared:
2/28/2022 9:53 am

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	319,835	2,608,439	0.122615	253,021	31,024
91.00	Nursing Program cost	0	2,608,439	0.000000	253,021	0
92.00	Allied health cost	0	2,608,439	0.000000	253,021	0
93.00	All other Medical Education	0	2,608,439	0.000000	253,021	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1313	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/28/2022 9:53 am
			Title XVIII	Hospital	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,012,823	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.453080	48,631	50.00
53.00	05300	ANESTHESIOLOGY	0.351984	40,075	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202241	219,498	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.161040	20,681	54.01
56.00	05600	RADIOISOTOPE	0.270570	2,868	56.00
58.00	05800	MRI	0.114065	15,251	58.00
60.00	06000	LABORATORY	0.267724	362,824	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.694859	20,947	62.00
64.00	06400	INTRAVENOUS THERAPY	0.047913	2,921	64.00
66.00	06600	PHYSICAL THERAPY	0.448161	106,452	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.358503	91,926	67.00
68.00	06800	SPEECH PATHOLOGY	0.297544	5,860	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
69.01	03160	CARDIOPULMONARY	0.457796	182,609	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.003423	145,809	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.875772	238,234	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.150063	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000	0	76.01
76.02	03950	DIABETIC EDUCATION	28.429248	0	76.02
76.03	03951	WOUND CARE	0.012201	0	76.03
76.04	03953	ALLERGY 123	0.000000	0	76.04
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
91.00	09100	EMERGENCY	1.314766	1,222	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.734518	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,505,808	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)		1,505,808	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1313 Component CCN: 14-Z313	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/28/2022 9:53 am	
Cost Center Description			Title XVIII	Swing Beds - SNF	Cost	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.453080	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.351984	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202241	36,600	7,402	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.161040	7,161	1,153	54.01
56.00	05600	RADIOISOTOPE	0.270570	0	0	56.00
58.00	05800	MRI	0.114065	0	0	58.00
60.00	06000	LABORATORY	0.267724	115,427	30,903	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.694859	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.047913	7,503	359	64.00
66.00	06600	PHYSICAL THERAPY	0.448161	208,555	93,466	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.358503	231,930	83,148	67.00
68.00	06800	SPEECH PATHOLOGY	0.297544	5,033	1,498	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.457796	43,987	20,137	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.003423	63,789	64,007	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.875772	97,149	85,080	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.150063	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000	0	0	76.01
76.02	03950	DIABETIC EDUCATION	28.429248	0	0	76.02
76.03	03951	WOUND CARE	0.012201	0	0	76.03
76.04	03953	ALLERGY 123	0.000000	0	0	76.04
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100	EMERGENCY	1.314766	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.734518	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		817,134	387,153	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)		817,134		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1313	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/28/2022 9:53 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,073,305 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	OPPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,073,305 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			5,124,038 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)			47,577 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			1,791,656 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			3,284,805 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			3,284,805 30.00
31.00	Primary payer payments			575 31.00
32.00	Subtotal (line 30 minus line 31)			3,284,230 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)			224,612 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			145,998 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			93,699 36.00
37.00	Subtotal (see instructions)			3,430,228 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			3,430,228 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			3,610,233 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)			-180,005 43.00
43.01	Balance due provider/program-PARHM (see instructions)			0 43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part I
Date/Time Prepared:
2/28/2022 9:53 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,420,552		3,530,833	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	07/14/2021	79,400	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		79,400	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,420,552		3,610,233	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		35,792		180,005	6.02
7.00	Total Medicare program liability (see instructions)		1,384,760		3,430,228	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: 14-1313

Period:

Worksheet E-1

Component CCN: 14-Z313

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 9:53 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,566,567		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,566,567		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		247,432		0	6.02
7.00	Total Medicare program liability (see instructions)		1,319,135		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 - SWING BEDS		Provider CCN: 14-1313 Component CCN: 14-Z313	Period: From 10/01/2020 To 09/30/2021	Worksheet E-2 Date/Time Prepared: 2/28/2022 9:53 am	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		946,989	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)		391,025	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		537	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,338,014	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,338,014	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,338,014	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		18,879	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,319,135	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,319,135	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		1,566,567	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)		-247,432	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparision of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1313	Period: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part V Date/Time Prepared: 2/28/2022 9:53 am
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,501,101	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)		1,501,101	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,501,101	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)		1,501,101	19.00
20.00	Deductibles (exclude professional component)		125,000	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,376,101	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,376,101	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		13,322	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		8,659	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		13,322	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,384,760	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)		1,384,760	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		1,420,552	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)		-35,792	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1313

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

Worksheet G

Date/Time Prepared:
2/28/2022 9:53 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	14,906,830	0	0	0	1.00
2.00 Temporary investments	646,750	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	6,353,705	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	503,671	0	0	0	7.00
8.00 Prepaid expenses	216,477	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	22,627,433	0	0	0	11.00
FIXED ASSETS					
12.00 Land	0	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	10,791,623	0	0	0	15.00
16.00 Accumulated depreciation	0	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	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	0	0	0	0	23.00
24.00 Accumulated depreciation	0	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	10,791,623	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	0	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	6,400,327	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	6,400,327	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	39,819,383	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	624,593	0	0	0	37.00
38.00 Salaries, wages, and fees payable	682,781	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	832,601	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	668,740	0	0	0	43.00
44.00 Other current liabilities	4,000,863	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	6,809,578	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	4,107,625	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	6,809,745	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	10,917,370	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	17,726,948	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	22,092,435	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)	22,092,435	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	39,819,383	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1313

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

Worksheet G-1

Date/Time Prepared:
2/28/2022 9:53 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		14,764,492		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7,327,943				2.00
3.00	Total (sum of line 1 and line 2)		22,092,435		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		22,092,435		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		22,092,435		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1313

Period:
From 10/01/2020
To 09/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,493,784		2,493,784	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	993,807		993,807	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,487,591		3,487,591	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,487,591		3,487,591	17.00
18.00	Ancillary services	3,642,188	30,781,616	34,423,804	18.00
19.00	Outpatient services	31,479	5,159,080	5,190,559	19.00
20.00	RURAL HEALTH CLINIC	0	4,934,973	4,934,973	20.00
20.01	RURAL HEALTH CLINIC II	0	311,457	311,457	20.01
20.02	RURAL HEALTH CLINIC III	0	803,256	803,256	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,741,016	2,741,016	22.00
23.00	AMBULANCE SERVICES	1,059	2,594,487	2,595,546	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,162,317	47,325,885	54,488,202	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,865,761		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	EMPLOYEE PHYSICALS -DEDUCTION	25,168			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)		25,168		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		27,840,593		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1313

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

Worksheet G-3

Date/Time Prepared:
2/28/2022 9:53 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	54,488,202	1.00
2.00	Less contractual allowances and discounts on patients' accounts	26,477,774	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,010,428	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,840,593	4.00
5.00	Net income from service to patients (line 3 minus line 4)	169,835	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	268,688	6.00
7.00	Income from investments	156,404	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	735,760	23.00
24.00	OTHER REVENUE	797,166	24.00
24.01	PROVIDER RELIEF FUND REVENUE	2,979,283	24.01
24.02	PAYCHECK PROTECTION PROGRAM REVENUE	2,200,609	24.02
24.03	GRANT REVENUE	20,198	24.03
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	7,158,108	25.00
26.00	Total (line 5 plus line 25)	7,327,943	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	7,327,943	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1313

Period: From 10/01/2020

Worksheet H

HHA CCN: 14-7202

To 09/30/2021

Date/Time Prepared: 2/28/2022 9:53 am

					Home Health Agency I	PPS
	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)
	1.00	2.00	3.00	4.00	5.00	6.00
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures		0		0	0
2.00	Capital Related - Movable Equipment		0		0	0
3.00	Plant Operation & Maintenance	0	0	0	0	0
4.00	Transportation	0	0	0	0	0
5.00	Administrative and General	142,328	-162	48,177	0	250,499
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	533,598	-608	0	0	532,990
7.00	Physical Therapy	0	0	0	0	0
8.00	Occupational Therapy	0	0	0	0	0
9.00	Speech Pathology	0	0	0	0	0
10.00	Medical Social Services	4,000	-5	0	0	3,995
11.00	Home Health Aide	34,626	-39	0	0	34,587
12.00	Supplies (see instructions)	0	0	0	0	0
13.00	Drugs	0	0	0	0	0
14.00	DME	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0
18.00	Clinic	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0
24.00	Total (sum of lines 1-23)	714,552	-814	48,177	0	822,071
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		
	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0
2.00	Capital Related - Movable Equipment	0	0	0	0	0
3.00	Plant Operation & Maintenance	0	0	0	0	0
4.00	Transportation	0	0	0	0	0
5.00	Administrative and General	0	250,499	0	250,499	0
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	0	532,990	0	532,990	0
7.00	Physical Therapy	0	0	0	0	0
8.00	Occupational Therapy	0	0	0	0	0
9.00	Speech Pathology	0	0	0	0	0
10.00	Medical Social Services	0	3,995	0	3,995	0
11.00	Home Health Aide	0	34,587	0	34,587	0
12.00	Supplies (see instructions)	0	0	0	0	0
13.00	Drugs	0	0	0	0	0
14.00	DME	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0
18.00	Clinic	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	822,071	0	822,071	0

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-1313

Period:

Worksheet H-1

HHA CCN: 14-7202

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 9:53 amHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
			Bldgs & Fixtures	Movable Equipment					
		0	1.00	2.00	3.00	4.00	4A.00		
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00	
2.00	Capital Related - Movable Equipment	0		0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	0	4.00	
5.00	Administrative and General	250,499	0	0	0	0	250,499	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	532,990	0	0	0	0	532,990	6.00	
7.00	Physical Therapy	0	0	0	0	0	0	7.00	
8.00	Occupational Therapy	0	0	0	0	0	0	8.00	
9.00	Speech Pathology	0	0	0	0	0	0	9.00	
10.00	Medical Social Services	3,995	0	0	0	0	3,995	10.00	
11.00	Home Health Aide	34,587	0	0	0	0	34,587	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	0	14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	822,071	0	0	0	0	822,071	24.00	
		Administrative & General	Total (cols. 4A + 5)						
		5.00	6.00						
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures							1.00	
2.00	Capital Related - Movable Equipment							2.00	
3.00	Plant Operation & Maintenance							3.00	
4.00	Transportation							4.00	
5.00	Administrative and General	250,499						5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	233,590	766,580					6.00	
7.00	Physical Therapy	0	0					7.00	
8.00	Occupational Therapy	0	0					8.00	
9.00	Speech Pathology	0	0					9.00	
10.00	Medical Social Services	1,751	5,746					10.00	
11.00	Home Health Aide	15,158	49,745					11.00	
12.00	Supplies (see instructions)	0	0					12.00	
13.00	Drugs	0	0					13.00	
14.00	DME	0	0					14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0					15.00	
16.00	Respiratory Therapy	0	0					16.00	
17.00	Private Duty Nursing	0	0					17.00	
18.00	Clinic	0	0					18.00	
19.00	Health Promotion Activities	0	0					19.00	
20.00	Day Care Program	0	0					20.00	
21.00	Home Delivered Meals Program	0	0					21.00	
22.00	Homemaker Service	0	0					22.00	
23.00	All Others (specify)	0	0					23.00	
23.50	Telemedicine	0	0					23.50	
24.00	Total (sum of lines 1-23)		822,071					24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-1313

Period:

Worksheet H-1

HHA CCN: 14-7202

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/28/2022 9:53 amHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-250,499	571,572 5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	532,990	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	3,995	10.00
11.00	Home Health Aide	0	0	0	0	34,587	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-250,499	571,572 24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		250,499 25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.438263 26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1313

Period:

Worksheet H-2

HHA CCN: 14-7202

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 9:53 amHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS				MVBLE EQUIP	
			BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	NEW CAP REL COSTS - WEST CAMPUS BUIL		
		0	1.00	1.01	1.02	1.03	2.00	
1.00	Administrative and General	0	0	3,599	0	0	8,159	1.00
2.00	Skilled Nursing Care	766,580	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	5,746	0	0	0	0	0	6.00
7.00	Home Health Aide	49,745	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	822,071	0	3,599	0	0	8,159	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE AND GENERAL	Subtotal	A&G HOSPITAL ONLY	MAINTENANCE & REPAIRS	
		4.00	4A	5.01	5A.01	5.02	6.00	
1.00	Administrative and General	120,048	131,806	12,059	143,865	0	15,538	1.00
2.00	Skilled Nursing Care	0	766,580	70,136	836,716	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	5,746	526	6,272	0	0	6.00
7.00	Home Health Aide	0	49,745	4,551	54,296	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	120,048	953,877	87,272	1,041,149	0	15,538	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.000000		0.000000			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1313

Period:

Worksheet H-2

HHA CCN: 14-7202

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 9:53 amHome Health
Agency I

PPS

Cost Center Description		MAINTENANCE & REPAIRS - WEST CAMPUS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	OPERATION OF PLANT - WEST CAMPUS BUI	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		6.01	7.00	7.01	7.02	8.00	9.00	
1.00	Administrative and General	0	0	0	0	43	13,213	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	43	13,213	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		HOUSEKEEPING - WEST CAMPUS BUILDING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.01	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1313

Period:

Worksheet H-2

HHA CCN: 14-7202

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 9:53 amHome Health
Agency I

PPS

Cost Center Description		MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		16.00	19.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	20,451	0	193,110	0	193,110		1.00
2.00	Skilled Nursing Care	0	0	836,716	0	836,716	180,075	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	6,272	0	6,272	1,350	6.00
7.00	Home Health Aide	0	0	54,296	0	54,296	11,685	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	20,451	0	1,090,394	0	1,090,394	193,110	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.215216	21.00
Cost Center Description		Total HHA Costs 28.00						
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	1,016,791						2.00
3.00	Physical Therapy	0						3.00
4.00	Occupational Therapy	0						4.00
5.00	Speech Pathology	0						5.00
6.00	Medical Social Services	7,622						6.00
7.00	Home Health Aide	65,981						7.00
8.00	Supplies (see instructions)	0						8.00
9.00	Drugs	0						9.00
10.00	DME	0						10.00
11.00	Home Dialysis Aide Services	0						11.00
12.00	Respiratory Therapy	0						12.00
13.00	Private Duty Nursing	0						13.00
14.00	Clinic	0						14.00
15.00	Health Promotion Activities	0						15.00
16.00	Day Care Program	0						16.00
17.00	Home Delivered Meals Program	0						17.00
18.00	Homemaker Service	0						18.00
19.00	All Others (specify)	0						19.00
19.50	Telemedicine	0						19.50
20.00	Total (sum of lines 1-19) (2)	1,090,394						20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1313
HHA CCN: 14-7202Period:
From 10/01/2020
To 09/30/2021Worksheet H-2
Part II
Date/Time Prepared:
2/28/2022 9:53 amHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS					EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	
		BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	NEW CAP REL COSTS - WEST CAMPUS BUIL (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)		
		1.00	1.01	1.02	1.03	2.00		
1.00	Administrative and General	0	1,594	0	0	8,204	714,552	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	1,594	0	0	8,204	714,552	20.00
21.00	Total cost to be allocated	0	3,599	0	0	8,159	120,048	21.00
22.00	Unit cost multiplier	0.000000	2.257842	0.000000	0.000000	0.994515	0.168005	22.00
Cost Center Description		Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	MAINTENANCE & REPAIRS - WEST CAMPUS (SQUARE FEET)	
		5A.01	5.01	5A.02	5.02	6.00	6.01	
1.00	Administrative and General	0	131,806	-143,865	0	1,594	0	1.00
2.00	Skilled Nursing Care	0	766,580	-836,716	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	5,746	-6,272	0	0	0	6.00
7.00	Home Health Aide	0	49,745	-54,296	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	953,877	0	0	1,594	0	20.00
21.00	Total cost to be allocated	0	87,272	0	0	15,538	0	21.00
22.00	Unit cost multiplier	0.000000	0.091492	0.000000	0.000000	9.747804	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1313

Period:

Worksheet H-2

HHA CCN: 14-7202

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/28/2022 9:53 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	OPERATION OF PLANT - WEST CAMPUS BUI (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING Agency I (SQUARE FEET)	HOUSEKEEPING - WEST CAMPUS BUILDING (SQUARE FEET)	
		7.00	7.01	7.02	8.00	9.00	9.01	
1.00	Administrative and General	0	0	0	27	1,594	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	27	1,594	0	20.00
21.00	Total cost to be allocated	0	0	0	43	13,213	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	1.592593	8.289210	0.000000	22.00
Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UISI)	PHARMACY (COSTED REQ UISI)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	0	2,781,745	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0	2,781,745	20.00
21.00	Total cost to be allocated	0	0	0	0	0	20,451	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.007352	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1313

Period:

Worksheet H-2

HHA CCN: 14-7202

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/28/2022 9:53 amHome Health
Agency I

PPS

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		19.00		
1.00	Administrative and General	0		1.00
2.00	Skilled Nursing Care	0		2.00
3.00	Physical Therapy	0		3.00
4.00	Occupational Therapy	0		4.00
5.00	Speech Pathology	0		5.00
6.00	Medical Social Services	0		6.00
7.00	Home Health Aide	0		7.00
8.00	Supplies (see instructions)	0		8.00
9.00	Drugs	0		9.00
10.00	DME	0		10.00
11.00	Home Dialysis Aide Services	0		11.00
12.00	Respiratory Therapy	0		12.00
13.00	Private Duty Nursing	0		13.00
14.00	Clinic	0		14.00
15.00	Health Promotion Activities	0		15.00
16.00	Day Care Program	0		16.00
17.00	Home Delivered Meals Program	0		17.00
18.00	Homemaker Service	0		18.00
19.00	All Others (specify)	0		19.00
19.50	Telemedicine	0		19.50
20.00	Total (sum of lines 1-19)	0		20.00
21.00	Total cost to be allocated	0		21.00
22.00	Unit cost multiplier	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1313

Period:

Worksheet H-3

HHA CCN: 14-7202

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 9:53 am

				Title XVIII		Home Health Agency I	PPS			
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)			
		0	1.00	2.00	3.00	4.00	5.00			
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION										
Cost Per Visit Computation										
1.00	Skilled Nursing Care	2.00	1,016,791		1,016,791	5,137	197.93	1.00		
2.00	Physical Therapy	3.00	0	320,536	320,536	2,135	150.13	2.00		
3.00	Occupational Therapy	4.00	0	127,309	127,309	1,060	120.10	3.00		
4.00	Speech Pathology	5.00	0	8,772	8,772	88	99.68	4.00		
5.00	Medical Social Services	6.00	7,622		7,622	20	381.10	5.00		
6.00	Home Health Aide	7.00	65,981		65,981	478	138.04	6.00		
7.00	Total (sum of lines 1-6)		1,090,394	456,617	1,547,011	8,918		7.00		
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits					
					Part B					
						Not Subject to Deductibles & Coinsurance	Subject to Deductibles			
		0	1.00	2.00	3.00	4.00	5.00			
Limitation Cost Computation										
8.00	Skilled Nursing Care		37900	0	50			8.00		
8.01	Skilled Nursing Care		44100	0	62			8.01		
8.02	Skilled Nursing Care		99914	0	3,123			8.02		
9.00	Physical Therapy		37900	0	17			9.00		
9.01	Physical Therapy		44100	0	9			9.01		
9.02	Physical Therapy		99914	0	1,309			9.02		
10.00	Occupational Therapy		37900	0	6			10.00		
10.01	Occupational Therapy		44100	0	9			10.01		
10.02	Occupational Therapy		99914	0	650			10.02		
11.00	Speech Pathology		37900	0	0			11.00		
11.01	Speech Pathology		44100	0	0			11.01		
11.02	Speech Pathology		99914	0	51			11.02		
12.00	Medical Social Services		37900	0	0			12.00		
12.01	Medical Social Services		44100	0	0			12.01		
12.02	Medical Social Services		99914	0	11			12.02		
13.00	Home Health Aide		37900	0	28			13.00		
13.01	Home Health Aide		44100	0	11			13.01		
13.02	Home Health Aide		99914	0	337			13.02		
14.00	Total (sum of lines 8-13)			0	5,673			14.00		
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)			
		0	1.00	2.00	3.00	4.00	5.00			
Supplies and Drugs Cost Computations										
15.00	Cost of Medical Supplies	8.00	0	33,384	33,384	33,270	1.003427	15.00		
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00		
Cost Center Description		Program Visits			Cost of Services					
		Part A	Part B		Part A	Part B	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance					Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
6.00	7.00	8.00	9.00	10.00	11.00					
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION										
Cost Per Visit Computation										
1.00	Skilled Nursing Care	0	3,235		0	640,304		1.00		
2.00	Physical Therapy	0	1,335		0	200,424		2.00		
3.00	Occupational Therapy	0	665		0	79,867		3.00		
4.00	Speech Pathology	0	51		0	5,084		4.00		
5.00	Medical Social Services	0	11		0	4,192		5.00		
6.00	Home Health Aide	0	376		0	51,903		6.00		
7.00	Total (sum of lines 1-6)	0	5,673		0	981,774		7.00		

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1313

Period:

Worksheet H-3

HHA CCN: 14-7202

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 9:53 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1		
		6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00
Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00	7.00	8.00	9.00	10.00	11.00
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	15,748	0	0	15,802	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of cols. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	640,304						1.00
2.00	Physical Therapy	200,424						2.00
3.00	Occupational Therapy	79,867						3.00
4.00	Speech Pathology	5,084						4.00
5.00	Medical Social Services	4,192						5.00
6.00	Home Health Aide	51,903						6.00
7.00	Total (sum of lines 1-6)	981,774						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1313

Period:

Worksheet H-3

HHA CCN: 14-7202

From 10/01/2020

Part II

To 09/30/2021

Date/Time Prepared:

2/28/2022 9:53 am

Title XVIII

Home Health

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.448161	715,225	320,536	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.358503	355,114	127,309	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.297544	29,480	8,772	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	1.003423	33,270	33,384	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.875772	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1313 HHA CCN: 14-7202	Period: From 10/01/2020 To 09/30/2021	Worksheet H-4 Part I-II Date/Time Prepared: 2/28/2022 9:53 am	
		Title XVIII	Home Health Agency I	PPS	
		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00
			Part A Services	Part B Services	
			1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)		0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	797,006	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	130,320	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	8,078	13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	221	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	50,196	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	985,821	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		0	985,821	24.00
25.00	Coinsurance billed to program patients (from your records)		0	0	25.00
26.00	Net cost (line 24 minus line 25)		0	985,821	26.00
27.00	Reimbursable bad debts (from your records)		0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	985,821	29.00
30.00	ROUNDING		0	-1	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	0	30.99
31.00	Subtotal (see instructions)		0	985,820	31.00
31.01	Sequestration adjustment (see instructions)		0	0	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0	31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)		0	0	31.75
32.00	Interim payments (see instructions)		0	985,820	32.00
33.00	Tentative settlement (for contractor use only)		0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIESProvider CCN: 14-1313
HHA CCN: 14-7202Period:
From 10/01/2020
To 09/30/2021Worksheet H-5
Date/Time Prepared:
2/28/2022 9:53 am

				Home Health Agency I	PPS
		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		0		985,820
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
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)				
Program to Provider					
3.01			0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50			0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		985,820
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)				
Program to Provider					
5.01			0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50			0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		0		985,820
				Contractor Number	NPR Date (Mo/Day/Yr)
		0		1.00	2.00
8.00	Name of Contractor				

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313

Period:

Worksheet M-1

Component CCN: 14-3457

From 10/01/2020
To 09/30/2021Date/Time Prepared:
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		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	2,295,421	0	2,295,421	-116,989	2,178,432
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	423,027	0	423,027	0	423,027
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	743,480	0	743,480	0	743,480
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)	3,461,928	0	3,461,928	-116,989	3,344,939
11.00	Physician Services Under Agreement	0	334,688	334,688	0	334,688
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	17,574	17,574	0	17,574
14.00	Subtotal (sum of lines 11 through 13)	0	352,262	352,262	0	352,262
15.00	Medical Supplies	0	96,914	96,914	0	96,914
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	96,241	96,241	0	96,241
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	193,155	193,155	0	193,155
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,461,928	545,417	4,007,345	-116,989	3,890,356
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	14,267	0	14,267	0	14,267
25.02	Chronic Care Management	28,340	0	28,340	0	28,340
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)	42,607	0	42,607	0	42,607
FACILITY OVERHEAD						
29.00	Facility Costs	0	10,148	10,148	0	10,148
30.00	Administrative Costs	524,310	735,526	1,259,836	0	1,259,836
31.00	Total Facility Overhead (sum of lines 29 and 30)	524,310	745,674	1,269,984	0	1,269,984
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,028,845	1,291,091	5,319,936	-116,989	5,202,947

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313

Period:

Worksheet M-1

Component CCN: 14-3457

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 9:53 am

				RHC I	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	2,178,432		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	423,027		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	743,480		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	3,344,939		10.00
11.00	Physician Services Under Agreement	0	334,688		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	17,574		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	352,262		14.00
15.00	Medical Supplies	0	96,914		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	96,241		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	193,155		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,890,356		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	14,267		25.01
25.02	Chronic Care Management	0	28,340		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	42,607		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	10,148		29.00
30.00	Administrative Costs	0	1,259,836		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	1,269,984		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	5,202,947		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313

Period:

Worksheet M-1

Component CCN: 14-3462

From 10/01/2020

Date/Time Prepared:

To 09/30/2021

2/28/2022 9:53 am

				RHC II		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	91,035	0	91,035	0	91,035	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	153,143	0	153,143	0	153,143	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	39,985	0	39,985	0	39,985	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	284,163	0	284,163	0	284,163	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	4,571	4,571	0	4,571	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	4,571	4,571	0	4,571	14.00
15.00	Medical Supplies	0	6,145	6,145	0	6,145	15.00
16.00	Transportation (Health Care Staff)	0	4,852	4,852	0	4,852	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	6,517	6,517	0	6,517	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	17,514	17,514	0	17,514	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	284,163	22,085	306,248	0	306,248	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	3,117	0	3,117	0	3,117	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	3,117	0	3,117	0	3,117	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	6,872	6,872	0	6,872	29.00
30.00	Administrative Costs	40,520	75,624	116,144	0	116,144	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	40,520	82,496	123,016	0	123,016	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	327,800	104,581	432,381	0	432,381	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313

Period:

Worksheet M-1

Component CCN: 14-3462

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 9:53 am

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	91,035	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	153,143	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	39,985	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	284,163	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	4,571	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	4,571	14.00
15.00	Medical Supplies	0	6,145	15.00
16.00	Transportation (Health Care Staff)	0	4,852	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	6,517	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	17,514	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	306,248	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	3,117	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	3,117	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	6,872	29.00
30.00	Administrative Costs	0	116,144	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	123,016	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	432,381	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313

Period:

Worksheet M-1

Component CCN: 14-8592

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 9:53 am

				RHC III		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	324,363	0	324,363	0	324,363	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	110,967	0	110,967	0	110,967	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	132,230	0	132,230	0	132,230	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	567,560	0	567,560	0	567,560	10.00
11.00	Physician Services Under Agreement	0	19,935	19,935	0	19,935	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	6,471	6,471	0	6,471	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	26,406	26,406	0	26,406	14.00
15.00	Medical Supplies	0	66,074	66,074	0	66,074	15.00
16.00	Transportation (Health Care Staff)	0	1,611	1,611	0	1,611	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	11,540	11,540	0	11,540	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	79,225	79,225	0	79,225	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	567,560	105,631	673,191	0	673,191	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	3,630	0	3,630	0	3,630	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	3,630	0	3,630	0	3,630	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	30,864	30,864	0	30,864	29.00
30.00	Administrative Costs	60,932	104,287	165,219	0	165,219	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	60,932	135,151	196,083	0	196,083	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	632,122	240,782	872,904	0	872,904	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313

Period:

Worksheet M-1

Component CCN: 14-8592

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 9:53 am

				RHC III	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	324,363	1.00	
2.00	Physician Assistant	0	0	2.00	
3.00	Nurse Practitioner	0	110,967	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	132,230	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	567,560	10.00	
11.00	Physician Services Under Agreement	0	19,935	11.00	
12.00	Physician Supervision Under Agreement	0	0	12.00	
13.00	Other Costs Under Agreement	0	6,471	13.00	
14.00	Subtotal (sum of lines 11 through 13)	0	26,406	14.00	
15.00	Medical Supplies	0	66,074	15.00	
16.00	Transportation (Health Care Staff)	0	1,611	16.00	
17.00	Depreciation-Medical Equipment	0	0	17.00	
18.00	Professional Liability Insurance	0	11,540	18.00	
19.00	Other Health Care Costs	0	0	19.00	
20.00	Allowable GME Costs			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	79,225	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	673,191	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	3,630	25.01	
25.02	Chronic Care Management	0	0	25.02	
26.00	All other nonreimbursable costs	0	0	26.00	
27.00	Nonallowable GME costs			27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	3,630	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	0	30,864	29.00	
30.00	Administrative Costs	0	165,219	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	196,083	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	872,904	32.00	

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN: 14-1313 Component CCN: 14-3457		Period: From 10/01/2020 To 09/30/2021		Worksheet M-2 Date/Time Prepared: 2/28/2022 9:53 am	
			RHC I		Cost			
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4			
	1.00	2.00	3.00	4.00	5.00			
VISITS AND PRODUCTIVITY								
Positions								
1.00	Physician	3.42	11,435	1	3	1.00		
2.00	Physician Assistant	0.00	0	2,100	0	2.00		
3.00	Nurse Practitioner	3.73	3,355	1	4	3.00		
4.00	Subtotal (sum of lines 1 through 3)	7.15	14,790		7	14,790	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	1.35	977			977	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)	8.50	15,767			15,767	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)					3,890,356	10.00	
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					42,607	11.00	
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,932,963	12.00	
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.989167	13.00	
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,269,984	14.00	
15.00	Parent provider overhead allocated to facility (see instructions)					1,700,897	15.00	
16.00	Total overhead (sum of lines 14 and 15)					2,970,881	16.00	
17.00	Allowable GME overhead (see instructions)					0	17.00	
18.00	Enter the amount from line 16					2,970,881	18.00	
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,938,697	19.00	
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					6,829,053	20.00	

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1313

Period:

Worksheet M-2

Component CCN: 14-3462

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

Date/Time Prepared:

2/28/2022 9:53 am

		RHC II		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.22	228	1	0
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	0.65	964	1	1
4.00	Subtotal (sum of lines 1 through 3)	0.87	1,192	1	1,192
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.87	1,192		1,192
9.00	Physician Services Under Agreements		0		0
					1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES					
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				306,248
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				3,117
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				309,365
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.989925
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				123,016
15.00	Parent provider overhead allocated to facility (see instructions)				103,930
16.00	Total overhead (sum of lines 14 and 15)				226,946
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				226,946
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				224,660
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				530,908

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1313

Period:

Worksheet M-2

Component CCN: 14-8592

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

Date/Time Prepared:

2/28/2022 9:53 am

		RHC III		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.60	1,924	1	1
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	0.52	1,451	1	1
4.00	Subtotal (sum of lines 1 through 3)	1.12	3,375	2	3,375
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.12	3,375		3,375
9.00	Physician Services Under Agreements		0		0
					1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES					
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				673,191
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				3,630
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				676,821
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.994637
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				196,083
15.00	Parent provider overhead allocated to facility (see instructions)				245,062
16.00	Total overhead (sum of lines 14 and 15)				441,145
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				441,145
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				438,779
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,111,970

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1313	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3		
		Component CCN: 14-3457		Date/Time Prepared: 2/28/2022 9:53 am		
		Title XVIII	RHC I	Cost		
				1.00		
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			6,829,053	1.00	
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			135,518	2.00	
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			6,693,535	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			15,767	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)			15,767	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			424.53	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)		380.21	380.21	334.42	8.00
9.00	Rate for Program covered visits (see instructions)		424.53	424.53	334.42	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		1,083	1,068	2,479	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		459,766	453,398	829,027	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	2	14	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	849	4,682	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	849	4,682	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	1,747,722		16.00
16.01	Total program charges (see instructions)(from contractor's records)			1,064,357		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			61,274		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			100,615		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.)			1,272,424		16.04
16.05	Total program cost (see instructions)		0	1,373,039		16.05
17.00	Primary payer amounts			0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			56,577		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			189,301		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1,373,039		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			63,671		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,436,710		22.00
23.00	Allowable bad debts (see instructions)			31,035		23.00
23.01	Adjusted reimbursable bad debts (see instructions)			20,173		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			31,035		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)			1,456,883		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			1,347,399		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)			109,484		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1313 Component CCN: 14-3462	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/28/2022 9:53 am	
		Title XVIII	RHC II	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			530,908	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			3,720	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			527,188	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,192	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)			1,192	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			442.27	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)	338.37	338.37	262.47	8.00
9.00	Rate for Program covered visits (see instructions)	442.27	442.27	262.47	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	49	51	113	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	21,671	22,556	29,659	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	73,886		16.00
16.01	Total program charges (see instructions)(from contractor's records)		49,972		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,625		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,881		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.)		53,576		16.04
16.05	Total program cost (see instructions)	0	57,457		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		3,035		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		8,862		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		57,457		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,240		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		58,697		22.00
23.00	Allowable bad debts (see instructions)		2,081		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		1,353		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		2,081		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)		60,050		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		45,197		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)		14,853		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1313 Component CCN: 14-8592	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/28/2022 9:53 am	
		Title XVIII	RHC III	Cost	
			1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,111,970	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			7,783	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,104,187	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,375	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			3,375	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			327.17	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)	279.78	279.78	285.19	8.00
9.00	Rate for Program covered visits (see instructions)	327.17	327.17	285.19	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	64	66	155	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	20,939	21,593	44,204	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	86,736		16.00
16.01	Total program charges (see instructions)(from contractor's records)		62,924		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,875		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		10,855		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.)		56,498		16.04
16.05	Total program cost (see instructions)	0	67,353		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		5,258		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		9,958		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		67,353		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,631		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		68,984		22.00
23.00	Allowable bad debts (see instructions)		1,863		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		1,211		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,863		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)		70,195		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		61,274		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)		8,921		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: 14-1313

Period:

Worksheet M-4

Component CCN: 14-3457

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 9:53 am

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3,344,939	3,344,939	3,344,939	3,344,939	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000866	0.004259	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,897	14,246	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	36,062	23,998	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	38,959	38,244	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,890,356	3,890,356	3,890,356	3,890,356	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,938,697	2,938,697	2,938,697	2,938,697	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.010014	0.009830	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	29,428	28,887	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	68,387	67,131	0	0	10.00
11.00	Total number of injections/infusions (from your records)	277	1,362	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	246.88	49.29	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	88	851	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	21,725	41,946	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		135,518			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)		63,671			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1313

Period:

Worksheet M-4

Component CCN: 14-3462

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 9:53 am

		Title XVIII		RHC II	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	284,163	284,163	284,163	284,163	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.002717	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	772	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	1,374	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	2,146	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	306,248	306,248	306,248	306,248	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	224,660	224,660	224,660	224,660	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.007007	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	1,574	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	3,720	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	78	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	47.69	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	26	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	1,240	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		3,720			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)		1,240			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1313

Period:

Worksheet M-4

Component CCN: 14-8592

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 9:53 am

		Title XVIII		RHC III	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	567,560	567,560	567,560	567,560	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.003117	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	1,769	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	2,943	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	4,712	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	673,191	673,191	673,191	673,191	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	438,779	438,779	438,779	438,779	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.006999	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	3,071	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	7,783	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	167	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	46.60	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	35	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	1,631	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		7,783			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)		1,631			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1313 Component CCN: 14-3457	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/28/2022 9:53 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,240,299	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		07/14/2021	107,100	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)		107,100	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,347,399	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		109,484	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,456,883	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1313 Component CCN: 14-3462	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/28/2022 9:53 am
		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		45,197	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)		45,197	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		14,853	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		60,050	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1313 Component CCN: 14-8592	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/28/2022 9:53 am	
			RHC III	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			61,274	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)			61,274	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			8,921	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			70,195	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00